TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with purs after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fined in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

OX 68760

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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First, Middle, Las | st) | | | | | 2. DATE OF MONTH | DEATH | YEAR | 3. TIME OF DEATH |
|---------------|---|---------------------------------|--|--------------------------------------|------------------------|---|---|-----------------------------|------------------------------|---|
| | GUY | Α | | CALL | IGAN. | JR | 09 | 01 | | 9:37 PM M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. Ia | st birthday) IF U | NDER 1 YEAR | IF UNDER 24 HR | (0.0 · 14 · 17 | | | HPLACE (State or Foreign |
| | 213-09-5828 | 1. M 2 F | 77 | YRS. | DATE | noons will | Apr. | 15,191 | | ryland |
| ~ | 9a. FACILITY NAME (If not institution, given | e street and number) | | 9b. | CITY, TOWN | OR LOCATION O | FOEATH | 9 | c. COUNTY OF | DEATH |
| DIRECTOR | NORTH ARUNDEL HE | OSPITAL AS | SOCIATI | ON | GLEN | BURNIE | 4 | | A.A. | COUNTY |
| EC | 10a. STATE 10b. COU | | | 10c. CITY, TO | WN OR LOCA | TION | | _ | | 10d. INSIDE CITY |
| ā | Maryland Anne | e Arundel | | Glen | Burni | 5 | | | | LIMITS? |
| FUNERAL | 1043 Fifth Stre | eet | | | 10 | 21060 | | | nited S | what country? States |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced | | IT EVER IN U.S. AI YES 2 XX MAR OR DATES | RMED NO | If yes, s | CENDENT OF HIS secify Cuban, Ma 3 2 X NO Sp | BPANIC ORIGIN? (Sixican, Puerto Rica pecify: | Specify Yea or an, etc.) | No — 14. RAC Blac Spec | E — American Indian, ck, White, etc. city: White |
| ED | 15. DECEDENT'S E | DUCATION | | ECEDENT'S USU | | | 16b, KI | IND OF BUSINE | ESS/INDUSTRY | WIIICC |
| E | (Specify only highest gri Elementary/Secondary (0-12) | College (1-4 or 5 | life | Sive kind of work on Do NOT use reti | ione during m red.) | ost of working | | | | 20000 |
| COMPLET | 4 | | PI | umber | | | HOI | me Imp | rovemen | nt |
| ш | 17. FATHER'S NAME (First, Middle, Last) Guy A. Calligar | n, Sr. | | | | | NAME (First, Midd Elizabe | | | |
| 0 8 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | ural Route Number, | | | |
| - | David Calligan | | 10 | 043 Fif | th St | , Glen | Burnie | , MD | 21060 | |
| | 20a. METHOD OF DISPOSITION 1X Burlel 2 Cremetion 3 R | emoval from State | cemetery, cri | AND DATEOF OIL | lace) | | OATE | | ION — City or T | |
| | 4 Donation 8 Other (Squilly) | псендея | <u> Glen</u> | Haven | | PK. 9-5 | | Gren | Burnie | , Maryland |
| | A | 211 | 0 | J 49 | Kirkl | ey-Rudd | lick Fun | | | |
| \vdash | . Klod or | May May | _ | _ | 421 C | rain Hw | y., SE, | Glen | Burnie | , MD 21061 |
| | 23. PART i. Enter the diseases, of ahock, or heart fellui | e. List only one cet | use on each line | eath. Do not e e. | nter the m | ode of dying, | auch as cardiso | c or respirate | ory arreat, | Approximate interval Batween |
| | iMMEDIATE CAUSE (Finel disease or condition | Caro | 10 F. 0 | | Ann | act 1- | arlieve | | | Onset and Death |
| | reaulting in death) | ONE | IDR AS A CONSE | OUENCE OF): | 700 | 77 | - | | | |
| z | | - Hon | tre | Mer | 011 | 1 | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO | (OR AS A CONSE | OUENCE OF | 4 | | - | | | |
| 2 | cause, Enter UNDERLYING CAUSE (Disease or injury | 13000 | OR AS A CONSE | OHENCE OF | ndè | cord | uls | | | |
| E | that initiated events resulting in death) LAST | 502 10 | (OH AS A CONSE | ODENCE OF): | | | | | | |
| E | | d | | | | | | | | |
| AL | PART II. Other algnificent condit | | | | e underlylr | g ceuse given | in Part i. 24 | In. WAS AN AUT | | b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO |
| EDICAL | Marcely | - The | elely | 1 | | | 1 | ☐ YES 2 1 | NO | COMPLETION OF CAUSE OF DEATH? |
| ME | | | | | | | | | | 1 TYES 2 NO |
| Z | | | | | | | | | | |
| S | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | ОТ | 28. P | LACE OF DEATH | (Check only one) | | | |
| PHYSICIAN | 27. MANNER OF DEATH | 1 Linpatterit 2 (| | 26b, TIME OF | - | ne 5 Resider | and DESCR | Specify) | IBY OCCUPED | |
| | 1 Natural 5 Pending | (Month, C | Day, Year) | INJURY | W | PRK? | | | 00001125 | |
| D BY | 2 Accident Investigation 3 Suicida 6 Could not | 28a. PLACE C | OF INJURY — At he stc. (Specify) | ome, farm, street | , fectory, offi | ia . | 28f. LOCATI | ON (Street and | Number or Rural | Route Number, |
| ETED | 4 Homicide determined | Buttotting. | atta (opocity) | | | | City or | Town, Stete) | | |
| PLE | 29a. CERTIFIER (Check only | YSICIAN: To the best of | f my knowledge, d | eath occurred at | the lime, det | and pleca, and | due to the cause | (a) and menner | as stated, | |
| | | INED: On the basis of a | examination and/or | investigation, in | my opinion, | death occured at | the time, data an | d place, and d | ue to the ceuse | |
| Ö | one) 2 MEDICAL EXAM | INCH. OIL THE DESIGN OF S | | | | | | | | a) and menner as stated. |
| E COMPL | 29b. SIGNATURE AND TITLE OF CERTIF | | | | | 29c. LICENSE | NUMBER | 25 | d. DATE SIGNE | D (Morth, Day, Year) |
| BE | 29b. SIGNATURE AND TITLE OF CERTIF | FIER | Enden | | | 29c. LICENSE D & | NUMBER | , 29 | d. DATE SIGNE | |
| ш | 29b. SIGNATURE AND TITLE OF CERTIL | FIER AU | SE OF DEATH (ITE | M 27) (Type, Print |) | Da | 11684 | | > 9/ | © (Month, Day, Year) 4184 |
| BE | 29b. SIGNATURE AND TITLE OF CERTIL 30. NAME AND ADDRESS OF PERSON CHACKUMKAL V. C | WHO COMPLETEO CAU | SE OF DEATH (ITE | M 27) (Type, Print |) | Da | 11684 | | > 9/ | © (Month, Day, Year) 4184 |
| BE | 29b. SIGNATURE AND TITLE OF CERTIL | WHO COMPLETEO CAU YRIAC, M.I | SE OF DEATH (ITE | M 27) (Type, Print CRAIN H |) | Da | 11684 | | > 9/ | 0 (Month, Day, Year) 4184 |



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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with Jours after death. Page 6 may be retained by the host | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache the filed within 72 hours after death with the State Debt, of Health and Mental Hydiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| ecuted with | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Deot, of Health and Mental Hyplene prior to burial, cremation, or removal. | atic event, the medica |
| the death certificate be exe | the attending physician are d Mental Hygiene prior to | injury, or other trauma |
| IN: The law requires that | ficate has been signed by State Dept. of Health an | item 23 shows any |
| R ATTENDING PHYSICIA | RECTOR: After this certi- urs after death with the | m 28 is marked, or |
| TO THE HOSPITAL OF | TO THE FUNERAL DIF | IMPORTANT: If Itel |

| | 1 - FOR STATE OF MARYLAND / DEPARTMEN CERTIFICAT | T OF HEALTH AND | MENTAL HYGIENE REG. NO. | |
|------------------|--|---------------------------------|--|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH | 3. TIME OF OEATN |
| | GARY COLE | | MONTH DAY | 94 21:10 M |
| 27 | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UND | ER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | 6. BIRTHPLACE (State or Foreign Country) |
| | 214-40-9330 1 X M 2 F 52 YRS. MONTHS 9a. FACILITY NAME (If not institution, give street and number) 9b. CIT | DAYS HOURS MIN. | May 4,1942 | Maryland OUNTY OF DEATN |
| DIRECTOR | | ltimore City | | |
| REC | 10e. STATE 10b. COUNTY 10c. CITY, TOWN | OR LOCATION | | 10d. INSIDE CITY LIMITS? |
| IC DI | Maryland Baltimore County Parkto | On 101. ZIP CODE | T 100 C | t VES 2 NO |
| FUNERAL | 17234 Evna Road | 21120 | 109. 0 | U.S.A. |
| S | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13 | . WAS DECENDENT OF HISPAI | NIC ORIGIN? (Specify Yea or No- | - 14. RACE — American Indian. |
| | 1 Never Married 2 Merried FORCES? 1 YES 2 NO | If yes, specify Cuban, Maxica | in, Puerto Rican, etc.) | Black, White, etc. |
| ВУ | 3 Widowed 4 Divorced | | | Specify: White |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give kind of work done | during most of working | 16b. KINO OF BUSINESS/ | |
| Ë | Elementery/Secondary (0-12) College (1-4 or 5+) life. Do NOT use retired. | , | 0-16 P 1 | , |
| MP | 4 Interior De | | Self-Empl | |
| | 17. FATNER'S NAME (First, Middle, Lest) | | ME (First, Middle, Maiden Surname | e) . |
| BE | Lewis Tunis Cole, Jr. 190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRES | Louise | | |
| 5 | | | Route Number, City or Town, State, Kton, Maryland | |
| | 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPO | | | - City or Town, Stata |
| | 1 Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crematic Creen Mount C | 9) | | ore, Maryland |
| | | . NAME AND ADDRESS OF FA | CILITY | ne, marytaiki |
| | John G. Reitz (m-00804) | 6500 York Ro | | Maryland 21212 |
| | 23. PART I. Enter the diseases, or complicatione that caused the death. Do not ente ahock, or heart feilure. List only one cause on each line. | er the mode of dying, suc | h aa cardiac or reapiratory | arrest, Approximate interval Batween |
| | IMMEDIATE CAUSE (Finel | | | Onset and Death |
| | disease or condition resulting in death) a. PLEUMOCYSTIS DUE TO (OR AS A CONSEQUENCE OF): | CARINII PI | VEUMONIA | IWEEK |
| 2 | - HIV | | | 8 VENOC |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | 9 101113 |
| 3 | cause. Enter UNDERLYING CAUSE (Disease or Injury | | | |
| 프 | that initiated eventa DUE TO (OR AS A CONSEQUENCE OF): | | | |
| H | resulting in death) LAST | | | |
| AL C | PART II. Other significent conditions contributing to deeth but not recuiting in the u | inderlying cause given in | Pert i. 24a. WAS AN AUTOPS | SY 24b. WERE AUTOPSY FINDINGS |
| 2 | | | PERFORMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | OF DEATH? |
| 2 3 | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEA | ATH YES I NO | 0 152 | 1 1 125 2 NO |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL | 28. PLACE OF DEATH (Ch | Y 4 | |
| Sic | EXAMINER? 1 YES 2 NO 1 Xinpatiant 2 ER/Outpatiant 3 DOA 4 No | R: ursing Nome 5 - Rasidence | 6 Other (Specify) | |
| Ě | 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) INJURY | 26c. INJURY AT WORK? | 28d. DESCRIBE NOW INJURY | DCCURED |
| BY I | 1 Natural 5 Pending M | 1 YES 2 NO | | |
| | 3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, ferm, street, fa | ctory, office | 28f. LOCATION (Street and Num. City or Town, State) | ber or Rural Route Number, |
| | 4 Homicide detarmined | | Only of John, Oleto, | |
| P | 29a. CERTIFIER (Check only) CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the | time, date and place, and due | to the cause(a) and menner as a | stated. |
| COMPLETED | one) 2 MEDICAL EXAMINER: Do the basis of examination and/or investigation, in my | | | |
| | 29b. SIGNATURE AND TITLE OF CENTIFIE | 29c. LICENSE NU | MBER 29d. D | DATE SIGNED (Month, Day, Year) |
| 386 | List WORKING MD | 240232 | 1E59847 > | 9/2/94 |
| 임 | AME AND ADDRESS OF PERSON WND COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | |
| | ERIC D. SKOLVICK, SOOI BROWNEDR RD | BALT A | 10 2/2/2 | |
| | 31. DATE FILED MACHEN 1994 32. REGISTERADO CHANGE | | | |
| | 9/2/79 | | | |

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| BALTIMORE, MARYLAND 21215-0020 | y be retained by the hospital or attending physici |
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| TIMOR | л. Раде 6 та |
| BAL | ours after death |
| | Š |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760. | L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death, Page 6 may be retained by the hospital or attending physici |
| DIVISION OF VITAL | OR ATTENDING PHYSICIAN: The law |

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should set att with the State Dept. of Health and Mental Hygene prior to burial, cremation, or removal.

**Marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law req TO THE FINETAL OFFERS. Miter this certificate has been be filed without from another wath with the State Dept. of IMPORTANT IN HEALTH SET THEM 23 Shu

| | 1 - STATE STATE OF MARYLAN | | TMENT OF H | | ENTAL HYGIEN | E | |
|------------------|---|----------------------|---------------------------------|--------------------------------|---|---------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | DATE OF OEATH | | 3. TIME OF DEATH |
| | CURTIS EARL CO | XC | | | 9 - 2 | | n/a M |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in) | yrs. last birthday) | IF UNDER 1 YEAR | | . DATE OF BIRTH (Month, Day, Year) | 8. BIRT | HPLACE (State or Foreign |
| | 213-60-6495 1 M M 2 G F 4 | 2 yrs. | 9b. CITY TOWN (| HOURS MIN. N | Mar. 12, | 1952 N. | Carolina |
| <u>۳</u> | 6307 Yorkshire Drive | | Baltin | | " | N/A | DEATH |
| DIRECTOR | RESIDENCE OF DECEDENT | | | | | 11/11 | |
| E | 10e. STATE 10b. COUNTY | | , TOWN OR LOCAT | ION | | | 10d. INSIDE CITY LIMITS? |
| 2 | MD N/A | Ba | ltimore | . ZIP CODE | | | 1 YES 2 NO |
| FUNERAL | 6307 Yorkshire Drive | | 101 | 21212 | | U.S.A | WHAT COUNTRY? |
| 5 | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U. 1. Never Married 2 Married FORCES? 1 X YES | | | ENDENT OF HISPANIC | | or No — 14. RAC | E — American Indian, ik, White, etc. |
| ВУ | 1 Never Merried 2 Merried FORCES 1 NO TES 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATE | | | 2 NO Specify: | derito riceri, etc.) | Spec | etty: |
| | 15. DECEDENT'S EDUCATION 16 | 6e. DECEDENT'S | USUAL OCCUPATION | ON . | 16b. KIND OF BUS | INESS/INDUSTRY | Black |
| COMPLETED | (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4 or 5 +) | | ork done during mo | | Too. KIND OF BOS | INESS/INDUSTRI | |
| 릴 | , | Clerk-T | ypist | | N/A | 1 | |
| ő | 17. FATHER'S NAME (First, Middle, Last) | | | 18. MOTHER'S NAME | (First, Middle, Maiden | Sumeme) | |
| BE (| Luby Cox | | | Helen C | ox | | |
| 10 | 19e. INFORMANT'S NAME (Type/Print) | 196. MAILING | ADDRESS (Street a | nd Number or Rural Rout | te Number, City or Town | , State, Zip Code) | |
| - | Helen Cox | 6307 | <i>C</i> orkshir | e Drive/Ba | altimore, | MD 2121 | 2 |
| | 1 Buriet 2 Cremetton 3 Removat from State cemete | rv. crematory or oti | F DISPOSITION (Na per place) | 1 | | CATION — City or To | The state of the s |
| | 4 ☐ Donation 5 ☐ Other (Specify) Gar 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | crison E | orest V | A Cemetery D ADDRESS OF FACILI | | ngs Mill | s, MD |
| | * Karen m. Koge | | | FUNERAL H | | | |
| - | 4 | | 1101 | E. NORTH A | VENUE/BAI | TIMORE, | MD 21202 |
| | 23. PART i. Enter the diseases, or complications that caused the shock, or heart failure. List only one cause on each IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CO.) | h Ilna. CEU | ULA | | | | Approximate Interval Between Onset and Death |
| CERTIFICATION | Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | |
| AL | PART II. Other significant conditions contributing to death but | not resulting in | the underlying | cause given in Par | rt I. 24a. WAS AN | | . WERE AUTOPSY FINDINGS |
| 5 | | | | | PERFORI | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: MEDIC | | | | | _ | | 1 YES 2 NO |
| ä | DID TOBACCO USE CONTRIBUTE TO CAUSE OF I | DEATH YE | S NO | UNCERTAIN | | | |
| <u>≥</u> | EXAMINER? HOSPITAL: | PLACE OF OEAT | | `\ | | | |
| 14S | 1 ☐ YES 2 NO 1 ☐ Inpetient 2 ☐ ER/Outpetie 27. MANNER OF DEATH 28e. DATE OF INJURY | ent 3 DOA | | 5 Residence 6 | | | |
| BY PI | 1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation | 200, TIME | RY WO | PRK? | d. DESCRIBE HOW IN | JURY OCCURED | |
| | 3 Suicide 8 Could not be determined 26e. PLACE OF INJURY — building, etc. (Specify) | At home, farm, at | reet, tactory, office | 26 | it. LOCATION (Street el City or Town, State) | nd Number or Rural | Raute Number, |
| 7 | 29e. CERTIFIER COMMON! CERTIFYING PHYSICIAN: To the beet of my knowledge | an doub comm | d and find a days of a days | | | | |
| COMPLETED | one) 2 MEDICAL EXAMINER: On the basis of examination er | | | | | | e) end manner ee steted. |
| BEC | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | 29c. LICENSE NUMBER | +5186 | 29d. DATE SIGNED | (Month, Day, Year) |
| 일 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH | I (ITEM 27) (Type, | Print) | +1 06 | 77136 | 7 | 4 |
| | 10 N GREENE ST. | | | | | | |
| | 31. DATE FILED (Month, September 1994 Selection of 1994 Selection of 1994 | ire | for t | | | | |
| | | 100 | - | | | | |

hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

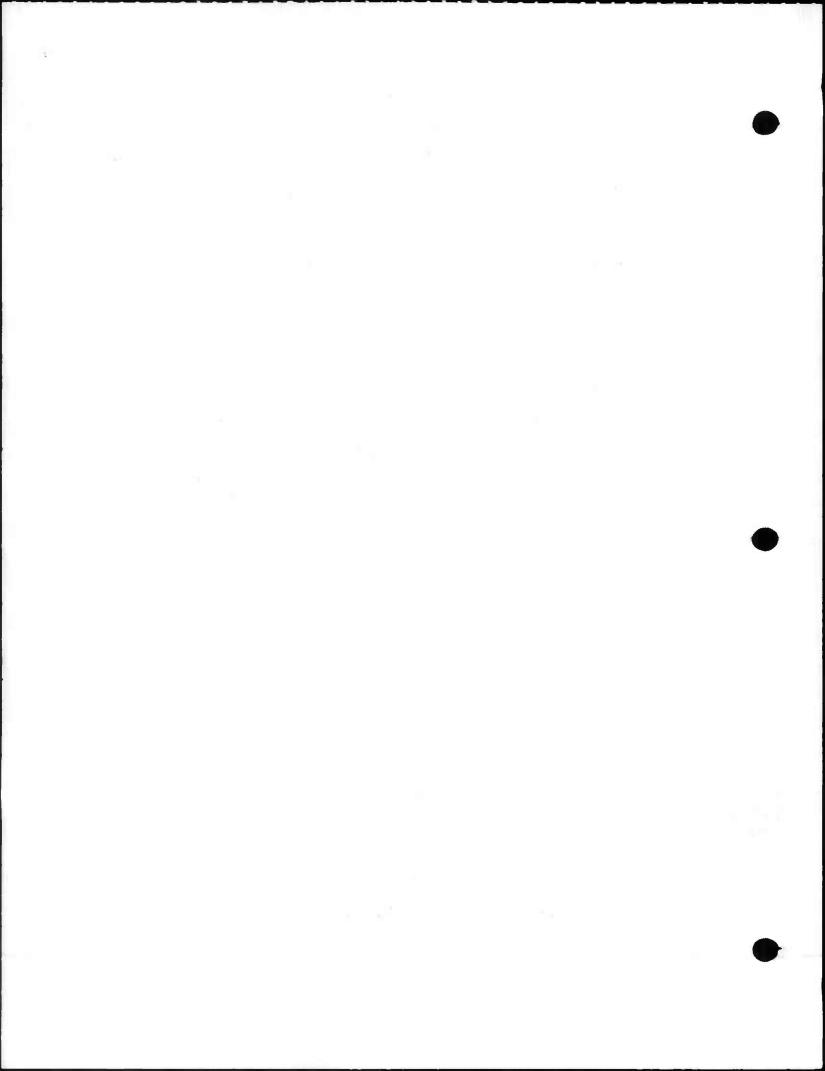
PHYSICIAN: The law requires that the death certificate be executed with

TO THE HOSPITM OF TO THE FUNERAL RED Be filed within 72 I

W OF VITAL RECORDS, P.O. BOX 68760

Common App. this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

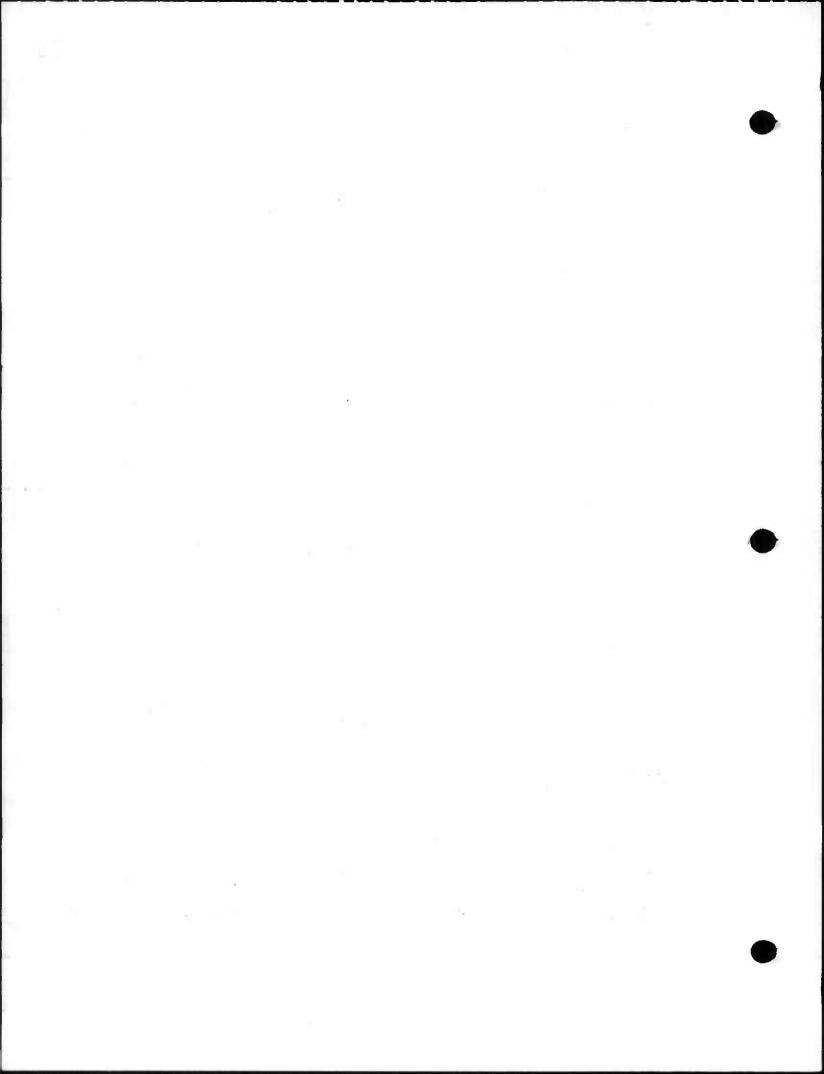
| | 1 - FOR STATE OF MARYLA | | TMENT OF H | | MENTAL HYGIENI REG. NO. | E | |
|--------------------|---|-------------------------------------|------------------------------------|--|--|----------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | 2. DATE OF DEATH MONTH DA | A AE | 3. TIME OF DEATH |
| | | | | | | 2 199 | 94 4:45 am |
| | 4. SOCIAL SECURITY NUMBER 216-80-5411 5. SEX 1 □ M 2 ◯ F 8. AGE (In | yrs. last birthday) _ | MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | March 12, 19 | (| BIRTHPLACE (State or Foreign Country) |
| | 9a. FACILITY NAME (If not institution, give street and number) | 00 | 96. CITY, TOWN C | R LOCATION OF DE | | 9c. COUNTY | laryland of DEATH |
| OR | Overlea Gardens Nursing C | enter | Balt | imore | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | 10c. CITY | , TOWH OR LOCAT | ION | | | 10d. INSIDE CITY |
| | Maryland | E | Baltimor | e | | | 1 X YES 2 NO |
| FUNERAL | 10e. STREET AND NUMBER | | 10f | ZIP CODE | | | OF WHAT COUNTRY? |
| JNE | 5837 Belair Road 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U | J.S. ARMED | 13. WAS DEC | 21206 | IC ORIGIN? (Specify Yes | | race - American Indian. |
| | 1 Never Married 2 Married FORCES? 1 YES | 2 X NO | If yes, spi | city Cuban, Mexican 2 X NO Specify. | , Puarto Rican, etc.) | | Black, Whife, etc. |
| ED BY | 3 🔀 Wildowed 4 🗌 Divorced 15. DECEDENT'S EDUCATION | In DECEDENTIA | ISUAL GOODERATE | | | <u> </u> | White |
| ETE | (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4 or 5+) | (Give kind of w life. Do NOT use | ork done during mo: o retired.) | st of working | 16b. KIND OF BUS | INESS/INDUST | RY |
| COMPLET | 6 | Home | maker | | | | |
| 00 | 17. FATHER'S NAME (First, Middle, Lest) Henry Hobell | | | | ME (First, Middle, Meiden : | Surneme) | |
| H | 19s. INFORMANT'S NAME (Type/Print) | 19h MAII ING | ADDRESS (Street o | - | Coleman | State 7in Con | |
| 5 | Mrs. Mary C. Hoffman | | | | Baltimore | | 21239 |
| | 20s. METHOD OF DISPOSITION 1 X/ Burlel 2 Cremation 3 Removal from State cemel | PLACE AND DATE O | F DISPOSITION (Na | me of | DATE 20c. LOC | CATION — City | or Town, Stata |
| | 4 Donation 5 Other (Specify) MOS 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Z | st Holy Re | deemer Cen | etery 9 | /6/94 Balt | timore, | Maryland |
| | Mark T. Zaryza | avoyna | I Leon | ard J. Ri | uck. Inc. | | |
| \dashv | 23. PART I. Enter the diseases, or complications that caused t | the death. Do no | 5305 | Hartord | Road Ba | Itimore | 21214 |
| | shock, or heart failure. List only one cause on eac | h lina. | | | | arrost, | intarval Batween Onset and Death |
| | disease or condition resulting in death) | andli | pul | me | ~ | | |
| _ | _ (\ | ONSEQUENCE OF |): 8 | | | | |
| 61 | Sequentially list conditions, If any, leading to immediata DUE TO (OR AS A CONSEQUENCE OF): | | | | | | |
| S | Cause, Enter UNDERLYING CAUSE (Disease or Injury that injurised executions DUE TO (OR AS A C | - Tow | | | | | |
| CERTIFICATION | that mithated eventa | rown | | | | | İ |
| | PART II. Other significant conditions contributing to death but | Ont resulting in | the underlying | cause alven in f | Part I. 24a. WAS AN / | ALITOREY I | DAL WEST AUTOSCH FININGS |
| PHYSICIAN: MEDICAL | - SIPPEG | THE FEBRUARY II | the underlying | cause given in r | PERFORI | MED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| MED | | | | | 1 YES 2 | l NO | OF DEATH? 1 YES 2 NO |
| N. | DID TOBACCO USE CONTRIBUTE TO CAUSE OF | DEATH YES | S NO | UNCERTAIN | | | |
| Sic. | EXAMINER? HOSPITAL: | | OTHER: | T-State of | | | |
| HYS | 27. MANNER OF DEATH 28e. DATE OF INJURY | 28b. TIME | OF 28c. INJU | 5 ☐ Realdence 8 | 3 Other (Specify) 28d. DESCRIBE HOW IN | IJURY OCCURE | D |
| ВУР | 1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation | ULMI | | ES 2 NO | | | |
| | 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — building, stc. (Specify | At home, term, st | reet, fectory, office | | 281. LOCATION (Street as City or Town, State) | nd Number or R | ural Route Number, |
| LEI I | 29e. CERTIFIER | | | | | | |
| COMPLETED | (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowled one) 2 MEDICAL EXAMINER: On the basic of examination a | | | | | | use(a) end menner as stated. |
| шШ | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | 29c. LICENSE NUM | | | NED (Month, Day, Year) |
| TO B | / awan | m1) | | D 31 | 464 | > | |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH Shoaib Hashmi, M.D. 821 N. | | | uite #308 | 2 | | |
| | 31. DATE FILED (Month, Day, Year) 32, REGISTRAR'S SIGNAT, | ŲRE | reet 3 | uite #300 | , | | |
| | SET U 6 1994 Juli Dansen K | much | | | | | |



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| | | 1 - FOR STATE REGISTRAR | STATE OF MARYLAN | | RTMENT OF I | | MENTAL HYGIEN | | | |
|--|---------------|--|--|---------------------|-------------------------|-----------------------|---|----------------|--------------------|--|
| | 2 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | | 3. TIME OF DEATH |
| | 8 | PATRICK J. | DOYLE | | | | | 03 | 94 | 6:02P M |
| | - 1 | 4. SOCIAL SECURITY NUMBER 5 | 6. SEX 6. AGE (In) | yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTH Countr | PLACE (State or Foreign |
| P | | 130 24 1381 | 1 x M 2 □ F 64 | YRS. | MONTHS DAYS | HOURS MIN, | | 1930 | | W YORK |
| 3 should | _ | 9a. FACILITY NAME (If not institution, give street | et and number) | | 96. CITY, TOWN | OR LOCATION OF DI | EATH | 9c. COUN | TY OF D | EATH |
| 1, 2, | DIRECTOR | 3721 BONVIEW A | AVE. | | | IMORE C | ITY | | ++ | +++ |
| permit. Pages | H | 10e. STATE 10b. COUNTY | | | Y, TOWN OR LOCA | TION | | | | 10d. INSIDE CITY LIMITS? |
| mit. | | 100. STREET AND NUMBER | + | BAL | TIMORE | | | | | XX YES 2 \ NO |
| ait per | FUNERAL | | _ | | 10 | f. ZIP CODE | | 10g. CITIZ | EN OF W | WHAT COUNTRY? |
| physician, burial-transit | N. | 3721 BONVIEW AVE | 2. WAS DECEDENT EVER IN U | S ADMED | 12 WAS DE | 2121 | ORIGIN? (Specify Ye | | 44 0100 | USA |
| physician. burial-tra | | 1 Never Married 2 Merried | FORDER 1 X YES | 2 NO | It yes, sp | ecify Cuban, Mexica | in, Puerto Rican, etc.) | a or No— | Black | — American Indian, c, Whita, etc. |
| | ВУ | 3 Widowed 4 Divorced | KORE | | 1 U YES | Specif | y. | | Speci | WHITE |
| r attending use as the | ED | 15. DECEDENT'S EDUCAT (Specify only highest grade con | TION 18 | e. DECEDENT'S | USUAL OCCUPATI | | 16b. KIND OF BU | SINESS/IND | JSTRY | MILIE |
| 5 7 | | | College (1-4 or 5 +) | life. Do NOT u | se retired.) | | | | | |
| the hospital o detached for once. | COMPLETED | 12 | | ĽA | BINET MA | KER | FURN | ITURE | | |
| 5 6 A | ш | 17. FATHER'S NAME (First, Middle, Lest) JOHN J. DOYLE | | | | | ME (First, Middle, Malden IE COURTNE | , | | |
| 5 should notified | TO B | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street | and Number or Rural | Route Number, City or Tow | vn, State, Zip | Code) | |
| e ge | F | JOAN F. WOODS | 5 | Box | 235 G | REENVILL | E, NEW YOR | K 12 | 083 | |
| (d) CT | | 20a. METHOD OF DISPOSITION 1 ☐ Burial 2 🔀 Cremation 3 ☐ Remova | | ACE AND DATE | OF DISPOSITION (No | anie of | DATE 20c. LO | CATION — C | afy or To | wn, State |
| Page 6 Il directo ner mu | | 4 Donation 5 Other (Specify) | | | CREMATO | | 19/06 BA | LTIMO | RE. | MARYLAND |
| funera funera | | 21. SIGNATURE OF FUNERAL SEINOGE LICEN | EE | | | | LE FUNERAL | | | |
| ic my | | 23. PART I Enter the diegaee, or con | nplicatione that caused the | he deeth. Do | not enter the mo | ode of dying, auc | HESACO AVE | iretory arre | st, | Approximate |
| ecuted within hours nd completely filled in 1 burial, cremation, or re atic event, the med | | * shock, or heert fellure. Lie IMMEDIATE CAUSE (Fine) disease or condition resulting in death) a | Author S C | leutic | | iovocal | la Dise | rol | | interval Between Onset and Death |
| certificate be ex nding physician a Hygiene prior to or other traum: | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST | DUE TO (OR AS A CO | | | | | | | |
| 0 0 = | | DART is Other elections conditions | amadh dha a da at ta | | | | | | | |
| ed by th and any ir | MEDICAL | PART ii. Other eignificent conditione of | contributing to deeth but | not reculting | in the underlyin | g ceuse given in | PERFO | RMED? | 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| | | DID TOBACCO USE CONTRIE | BUTE TO CAUSE OF | DEATH YI | S NO | UNCERTAII | VES : | ited | | 1 TES 2 NO |
| N: The Is icate has State De item 2 | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. | PLACE OF DEA | TH (Check only one) | | | | | |
| CLAN: ertifica the Sta | YSI | | ☐ Inpatient 2 ☐ ER/Outpatis | nnt 3 🗆 DOA | OTHER: 4 - Nursing Hore | ne 5XX ealdenca | 8 Other (Specify) | | | |
| NG PHYSICIAN: The feet this certificate sath with the State marked, or item | ву РНУ | 27. MANNER OF DEATH 1 Hetural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIM | JURY WO | PURY AT DRK? YES 2 NO | 28d, DESCRIBE HOW | INJURY OCC | URED | |
| . OR ATTENDING PHYSICIAN: The law DIRECTOR: After this certificate has bours after death with the State Dept Item 28 is marked, or item 23 | ED | 3 Suicide 8 Could not be detarmined | 28e. PLACE OF INJURY — building, atc. (Specify) | At home, term, | street, factory, offic | | 28f. LOCATION (Street City or Town, Stete) | and Number o | or Rural R | oute Number, |
| OR DIRE | LET | 29a. CERTIFIER 1 CERTIFYING PHYSICIA | N: To the best of my knowledge | ga, death occurr | ed at the time, date | and pleca, end due | to the ceuse(a) and ma | Oper ee state | d. | |
| 절 보었 = | OMPL | Laur Committee C | On the basis of examination as | | | | | | |) and manner as stated. |
| E HOSPI E FUNER I within RTANT: | E C | 29b. SIGNATURE AND TITLE OF CERTIFIER | 41 . | | | 29c. LICENSE NUM | ABER | 29d. DATE | SIGNED | (Month, Day, Year) |
| TO THE HOSPI TO THE FUNER DE filed within | TO BE | 30. NAME AND ADDRESS OF PERSON WHO C | King , | (C) | Drint) | O.CM | .E. | | EPI | |
| | | - 1 | | | | eet, Ba | ltimore, | Mary | lan | id 21201 |



spital or attending physician. BALTIMORE, MARYLAND 21215-0020

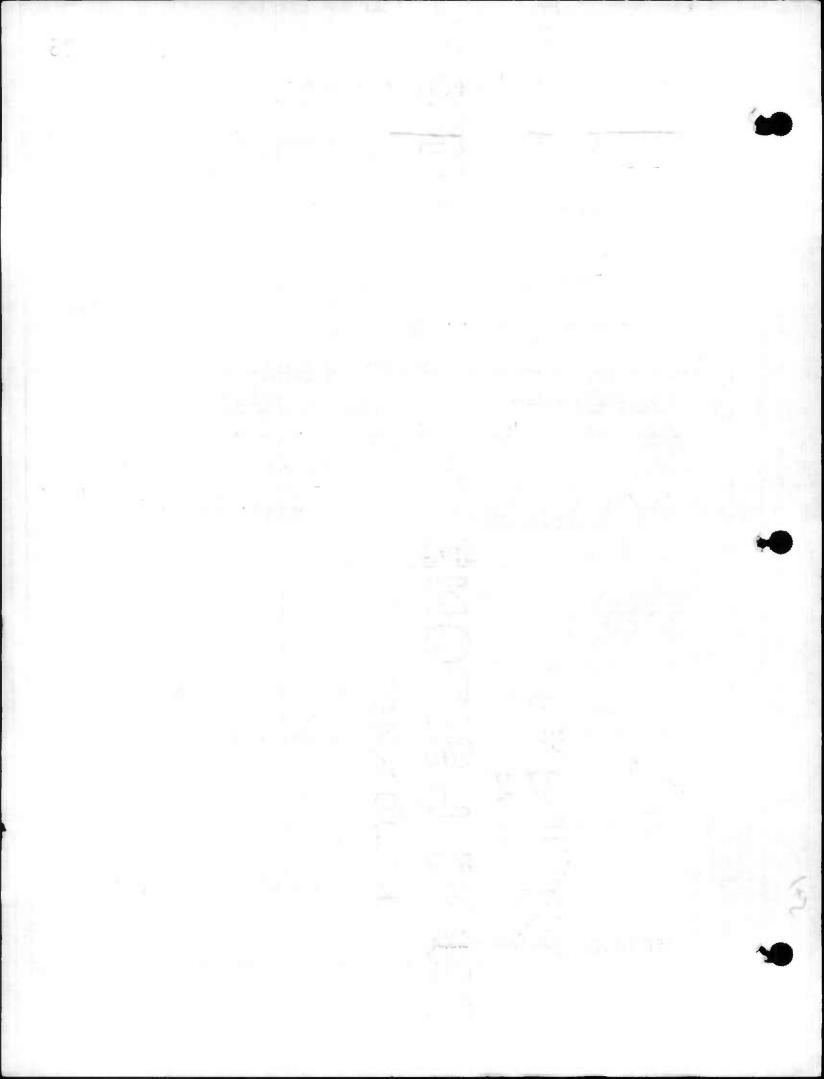
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| yours after death. Page 6 may be retained by the hospital or attending physician. | certificate has been signed by the attending physician and completely flied in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should he has stare per or Health and Mental Horiere not in burial cremation, or removal | e medical examiner must be notified at once. |
|---|--|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. gours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the first study within 2 hours after death with the State Dest of Health and Mental Mollege infort in build cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | | | | | | | 94 | 26006 |
|-------------|--|---|---|---------------------|-------------------------------------|---|--------------------------|--|
| | Item#1 Per F.: FOR 1. STATE | STATE OF MARYLANI | D / DEPARTM | MENT OF H | EALTH AND | MENTAL HYGI | ENE | |
| | REGISTRAR | | CERTIFIC | | DEATH | REG. | | |
| | 1. OECEDENT'S NAME (First, Middle, Last) | DOROTHY ELIZ | ABETH | DODD | | 2. DATE OF DEATH | DAY YE | 3. TIME OF OEATH |
| | | | | | | - | 3/ 9 | |
| | 4. SOCIAL SECURITY NUMBER | | MO | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN, | 7. DATE OF BIRTN (Month, Day, Yea 03/22/1 | 2000 | BIRTNPLACE (State or Foreign Country) |
| | 217=07-3365 | 1 M 2 X F 74 | YRS. | | | | | Maryland |
| _ | 9e. FACILITY NAME (If not institution, give st | | 98 | | R LOCATION OF DI | | 9c. COUNTY | |
| DIRECTOR | Charlotte Hall | Veterans Home | | Cha | rlotte t | iall | (| Charles |
| <u> </u> | 10a. STATE 10b. COUNTY | , | 10c. CITY, T | OWN OR LOCAT | ION | | | 10d. INSIDE CITY |
| 등 | Maryland | Harkord | | | Joppo | ι | | 1 YES 2 NO |
| | 10a. STREET AND NUMBER | 0 | | 101 | ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? |
| FUNERAL | 115 Driftwood Co | urt | | | 2108 | 35 | Un | ited States |
| 3 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 | ARMED | 13. WAS DEC | ENCENT OF NISPAI | NIC ORIGIN? (Specif) | Yes or No— 14. | RACE — American Indien, |
| | 1 Never Married 2 Married | IF YES, GIVE WAR OR DATES | | | cify Cuben, Mexice 2 X NO Specif | n, Puerlo Rican, atc. y: |) | Black, White, etc. Specify: |
| BY | 3 X Widowed 4 Divorced | WW II U.S. | Army | | • | | | white |
| 8 | 15. DECEDENT'S EDUC (Specify only highest grade | CATION 16st completed) | Give kind of work | done during mo | | 16b. KINO OF | BUSINESS/INDUS | THY |
| " | Elementary/Secondary (0-12) | College (1-4 or 5+) | ilfe. Do NOT use re | , | | 0:4 | Harrata | + = P |
| COMPLET | 8th Grade 17. FATNER'S NAME (First, Middle, Last) | | rooa se | wice s | | or Cit | - | lac |
| | | eum P é la | | | | tle Marie | | :000 |
| B | George Sanders S | uncon | 10h MAII INC AD | DBERR /Dimer o | | Route Number, City or | | |
| 2 | Marie Robier | | | | | oppa. Mar | | |
| | | 20h BI | ACE AND DATE OF | | | | LOCATION - CIN | |
| 1 1 | 20a. METNOD OF OISPOSITION 1 Burlel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify) | oval from State of comp | | | ry 9/3, | | | re, Maryland |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | | uk Luwn | 22. NAME AN | ID ADDRESS OF FA | CILITY | | |
| | 1/h./h/ | 21/ | | | | | | Dundalk, Inc. |
| | · CIM II | - Joseph | | | | ave. Dur | | |
| | 23. PART I. Enter the diseases, or cahock, or haert feilure. | complications that caused the List only one cause on each | | entar tha mo | da of dying, suc | ch ae cardiac or n | eapiretory arrest | Approximate Interval Between |
| 1 1 | IMMEDIATE CAUSE (Final disease or condition | 001 | 00 | | | | | Onset and Death |
| | resulting in death) | | U | | | | | |
| | | OUE TO (OR AS A CO | NSEQUENCE OF): | | | | | |
| RTIFICATION | Sequentially list conditions, | b DUE TO (OR AS A CO | NSEQUENCE OF: | - | | | | |
| F | if any, leading to immediate ceuse. Enter UNDERLYING | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | |
| [윤] | CAUSE (Disease or injury that initiated events | DUE TO (OR AS A CO | NSEQUENCE OF): | | | | | |
| | reaulting in deeth) LAST | 4 | | | | | | |
| 8 | DART II ON THE INTERNATIONAL CONTRACTOR | | | | ALTERNATION IN | man I am | | |
| MEDICAL | PART II. Other significent condition | e contributing to death out i | not reaulting in | tne undertyin | g ceuse given in | | S AN AUTOPSY REOPMEO? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO |
| ă | | | | | | 1 🗆 YE | S 2 NO | OF DEATH? |
| | | | | | | _ | | 1 TYES 2 NO |
| PHYSICIAN: | | | | | | | | |
| 0 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | To | 26. PI | LACE OF DEATH (C | heck only one) | | |
| X | 1 YES 2 NO | 1 Inpatient 2 ER/Outpatie | | | | 6 Other (Specify, | | |
| 표 | 27. MANNER OF DEATH 1 Natural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME C | Y WC | ORK? | 28d. DESCRIBE H | OW INJURY OCCUI | RED |
| B | 2 Accident Investigation | 26a. PLACE OF INJURY — | At home, form, etc. | | YES 2 NO | 201 LOCATION (S) | met and Number or | Rural Route Number, |
| 8 | 3 Suicide 6 Could not be 4 Nomicide determined | building, etc. (Specify) | AL FIOTHS, IETHI, SUIS | ret, factory, offic | | City or Town, | | rural route number, |
| COMPLETED | 29e. CERTIFIER | | | | | 1 | | |
| MP | (Check only | ICIAN: To the best of my knowledg IR: On the basic of examination or | | | | | | |
| 8 | | | wor investigation, | ту оршон, с | | | | |
| H | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | | 29c. LICENSE NU | | 29d. DATE S | IGNED (Marith, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON | COMPLETED CAUSE OF DEATH | /ITEM 27 /See 2 | rint) | 0296 | <i>J</i> / | 49 | 1/1/19 |
| | | | | | | | | |

Jahr 32 DEGISTRAR'S CONAJURE 31. DASE ELEP (NOTE: DE 1994

OMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)



3. TIME OF SEATH

a. BIRTHPLACE (State or Foreign

10d. INSIDE CITY

1 X YES 2 NO

Interval Between

Onset and Death

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 TYES 2 NO

02/94

Maryland

14. RACE — American Indian, Black, White, etc.

Specify: Black

Country)

REG. NO

| 8 | agu. |
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| , MARYLAND 21215-002 | Page 6 may be retained by the hospital or attending ply |
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| BALTIMORE, I | within Jours after death |
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FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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B

Segre 2, 1994 ANGELA ROBERTA BOLES 165 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Yea DAYS HOURS 1 M 2 F 213-62-1270 41 April 4 permit, Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Agnes Hospital Baltimore RESIDENCE OF DECEDENT 10m. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION Maryland Baltimore FUNERAL 10e, STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? burial-transit 4606 Manordene Road Apt. C-1 21229 U.S.A. ysician 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 1 Never Married 2 Married
3 Wildowed 4 Divorced FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES BY the 98 ETED. 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY use (Specify only highest grade compl ò Elementary/Secondary (0-12) College (1-4 or 5+) COMPL be detached Teller - Accountant Banking Industry 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surn Robert Lee, F Florine Patterson BE page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Kevin Lee 609 S Walter Reed Dr #633A, Arlington, VA222014 9 20a. METHOD OF DISPOSITION

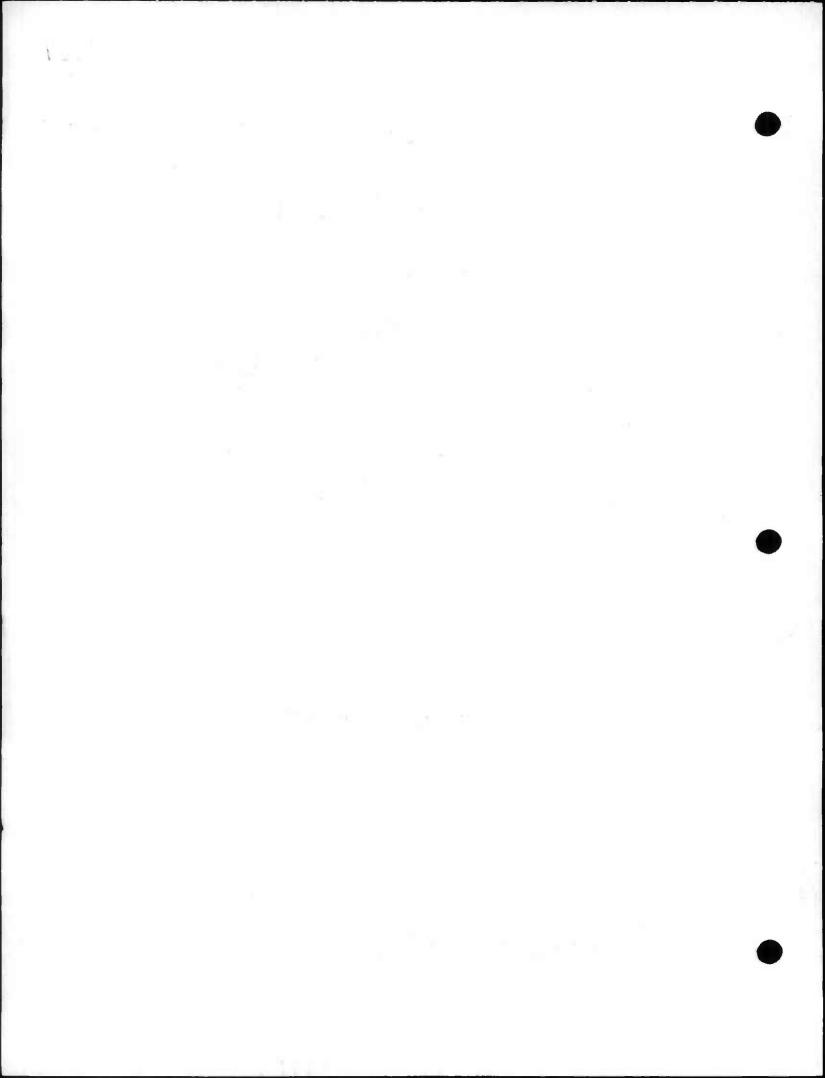
10 Burlel 2 Cremetion 3 Removal from State PLACE AND DATE OF DISPOSITION (Nama of DATE 20c. LOCATION — City or Town, State must funeral director, Western Star Cemetery ☐ Donation 5 ☐ Other (Specify) 9/6 Catonsville, MD 122. NAME AND ADDRESS OF FACILITY
Marshall W. Jones, Jr. Funeral Home PA ехатіпег 21. SIGNATURE OF FUNERAL SERVICE DICENSEE 4101 Edmondson Ave Baltimore, MD21229 in by the 94 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. 0 filled **IMMEDIATE CAUSE (Final** the cremation, disease or condition · ANOXIC BRAIN DAM 45E attending physician and completely reaulting in death) event, DUE TO (OR AS A CONSEQUENCE OF) executed w Hygiene prior to burial, Pulmonary Edema DUE TO (OR AS A CONSEDUENCE OF): traumatic CERTIFICATION Sequentistiy list conditions, if sny, leading to immediate csuse. Enter UNDERLYING CAUSE (Disease or injury 2 certificate other DUE TO (OR AS A CONSEQUENCE OF): that initisted events resulting in death) LAST 6 the death signed by the atter injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? requires that any PANCREATITIS Alcoholism of Health 1 TYES 2 T NO Shows been DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\precedent \) NO \(\precedent Dept. PHYSICIAN: MP 23 TO THE HOSPITAL DR ATTENDING PHYSICIAN; The law TO THE FUNERAL DIRECTOR: After this certificate has i be filed within 72 hours after death with the State Dept IMPORTANT; It liem 28 is marked, or liem 23 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: 28. PLACE OF DEATH (Check only one) OTHER: 1 TYES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending M 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide determined COMPLET 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) 296. SIGNATURE AND TITLE DE CERT BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 91 D44404 0 30. NAME AND ADDRESS OF PERSON WHD COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Jelin Studior Redall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

OHMH-16 Rev 1/89



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| , MAKYLAND 21215-0020 | Page 6 may be retained by the hospital or attending physician |
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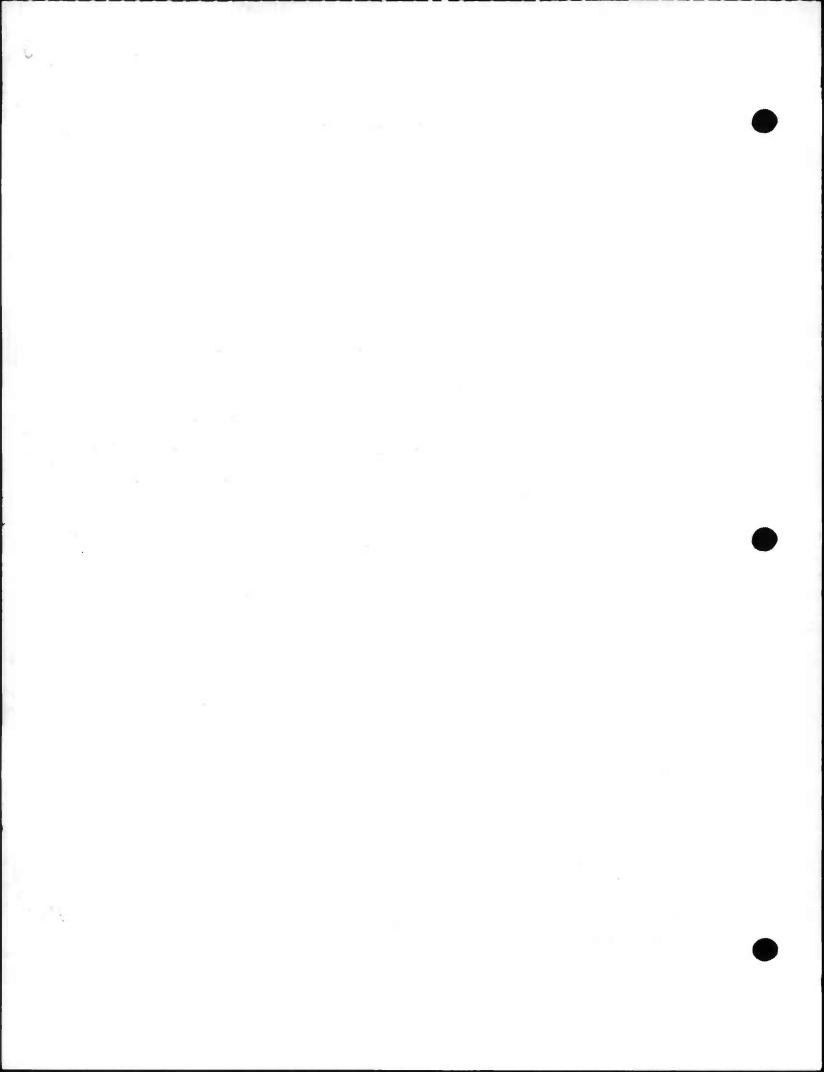
DIVISION OF VITAL RECORDS, P.O. BOX 68760.

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Jours after death. Page 6 may be retained by the hospital or attending physician. | THE WERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Places | De mind way 77 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | Approved it tem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
|---|--|--|---|--|
| TO THE H | | be filed wi | MROFRA | |

1, 2, 3 should

| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFICA | | | MENTAL HYGI REG. | | | |
|---------------|--|---|--|---------------------------|--------------------------------|--|-----------------------|-------------|---|
| | OECEDENT'S NAME (First, Middle, Last) | Louis Edw | ard Flai | g,Jr. | | 2. DATE OF DEATH MONTH AUG . 31 | ~ 1994 | YEAR | 3. TIME OF DEATH 5.30 A. M |
| | 4. SOCIAL SECURITY NUMBER 216-24-6656 | 5. SEX 6. AGE | | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Yea, 9/20/19 | 28 | Country | PLACE (State or Foreign |
| IOR | 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN Millersville, Md. | | | | | | | . CO | |
| DIRECTOR | maryland A, | A,Co. | | ersvi | on 11e,Md. | | | | 10d. INSIDE CITY LIMITS? |
| FUNERAL | 100. STREET AND NUMBER 557 Jano | don Ct. | | | ZIP CODE 1108 | | | ZEN OF W | HAT COUNTRY? States |
| BY FUN | 11. MARITAL STATUS 1 Never Married ZY Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IF FORCES? 12 YE YES GIVE WAR OR D KOrea | N U.S. ARMEO 2 NO ATES | If yes, spe | | NIC ORIGIN? (Specify in, Puerto Ricen, etc. | | Black | American Indian, White, atc. |
| COMPLETED | 15. OECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 +) | 18a. DECEDENT'S USU (Give kind of work life. Do NOT use refi | done during mos fred.) | N t of working | | BUSINESS/IND | | |
| | 12th.Grade 17. FATHER'S NAME (First, Middle, Last) Louis Edwa | 6 years ard Flaig, | Manage | ment | 18. MOTHER'S NA | ME (First, Middle, Mai | troni | | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) Mrs. Irene J. Fla | | | | nd Number or Rural | Aoute Number, City or llersvil | Town, State, Zip | Code) | 1108 |
| | 20a, METHOD OF DISPOSITION L Burlet 2 Cremation 3 Remo | 200 | PLACE AND DATE OF DI | SPOSITION (Nat | ne of | OATE 20c. | LOCATION — | City or Tov | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | Chriman | 1.44 | | | eral Hor | | | . 21122 t.Rd. |
| CERTIFICATION | 23. PART I. Enter the diagases, or cahock, or heart failura. I iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A | ach lina. CONSEQUENCE OF): CONSEQUENCE OF): CONSEQUENCE OF): | Cash | the of dying, such | Cancer | | | Approximate interval Batwan Onset and Deeth |
| EDICAL | PART II. Other aignificant conditions | s contributing to death b | ut not resulting in th | e undarlying | cause given in | PER | AN AUTOPSY FORMED? | | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| HYSICIAN: M | DID TOBACCO USE CONTR | | 28. PLACE OF OEATH (C | heck only one) | UNCERTAI | N D | | | 1 YES 2 NO |
| YSIC | 1 YES 2 NO | HOSPITAL: 1 Inputiant 2 ER/Outp | atlant 3 DOA 4 D | | | 8 Other (Specify) | | | |
| = | 27. MANNER OF DEATN 1 Natural 5 Pending | (Month, Day, Year) | 28b. TIME OF INJURY | M 1 Y | RY NT IK? ES 2 □ NO | 28d. OEŞCRIBE NO | W INJURY OCC | UREO | |
| IED B | 2 Accident Investigation 3 Suicide 8 Could not be 4 Nomicide determined | 28a. PLACE OF INJURY building, atc. (Spec | — At home, term, street | | | 281. LOCATION (Str. City or Town, St | et and Number ste) | or Rural Ad | oute Number, |
| COMPLET | | CIAN: To the best of my know R: On the basis of axamination | | | | | | | and manner as stated. |
| | 29b. SIGNATURE AND THE OF CERTIFIER | M | De Tuc | Mo | 29c. LICENSE NUN | ABER SS | 29d. DATE | SIGNED (| Moren of says |
| | 30. NAME AND ACCRESS OF PERSON WHO | Mars.D. | 1600SC1 | ginti | Wishon | ruf 4/0, 0 | IPA By | אינות | NJ. 2106/ |
| | SEP 0 6 1994 | 32. REGISTRAR'S SIGN | | | | | | , | |





hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| be retained by the hospital or attending physician. | is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | | be notified at once. |
|---|--|--|---|
| THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within rouns after death. Page 6 may be retained by the hospital or attending physician. | e attending physician and completely filled in by the funeral director, pag | fental Hygiene prior to burial, cremation, or removal, | nd, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Inji |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTI | | | MENTAL HYGIE | | | |
|---|--|---|---------------------|--------------------------------------|--|----------------|-------------------|-------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Lest) | Ř | Rodr | | | 2. DATE OF DEATH | DAY | VEAR | 3. TIME OF DEATH 12:50 P. M |
| | 5. SEX 6. AGE (| in yrs. last birthday) III | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 1, 13. | 8. BIRTHP | LACE (State or Foreign |
| | 1 ☑ M 2 ☐ F 71 YRS. MONTHS DAYS HOURS | | | | (Month, Day, Year) Aug. 12, | 1923 | West | Virginia |
| 9e. FACILITY NAME (If not institution, give stre | | | | OR LOCATION OF DE | ATH | 9c. COU | NTY OF DEA | |
| Carroll County Ger | neral Hospit | | Westmi | | | Cai | roll | |
| | 1.1 | | OWN OR LOCAT | TION | | | 1 | IOd. INSIDE CITY LIMITS? |
| Maryland Carro | <u> </u> | Woodh | | . ZIP CODE | | Free com | | YES 2 NO |
| 5165 Braddock Rd. | | | | 21797 | | | | tates |
| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN | | | | IC ORIGIN? (Specify Y | | 14. RACE - | - American Indian |
| 1 Never Merried 2 Merried | FORCES? 1 YES | | If yes, sp | ecify Cuben, Mexican 2 NO Specify | n, Puerto Rican, etc.) | | Black, Specify | White, etc. |
| 3 Widowed 4 Divorced | | | <u> </u> | | | | | White |
| 15. DECEDENT'S EDUCA (Specify only highest grade co | empleted) | 16a. DECEDENT'S US (Give kind of work life. Do NOT use re | done during mo | ON st of working | 16b. KIND OF B | USINESS/IND | USTRY | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | Sales | жива.) | | Retail | 1 | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 16 MOTHER'S NAI | ME (First, Middle, Maide | | | |
| Roy Rodney Furrow | , Sr. | | | Rose Co | | a Sometie) | | |
| 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAILING AD | DRESS (Street a | | loute Number, City or To | wn, State, Zip | Code) | |
| Roy Furrow, III | | | | | Burnie, 1 | | | |
| 26e. METHOD OF DISPOSITION 1 Disposition 3 Remove | | PLACE AND DATE OF C | | me of | DATE 20c. L | OCATION — | Clty or Town | n, State |
| 4 Donation 5 Other (Specify) | Ce | etery, cremetory or other edar Hill | | rv 9-2-94 | 1 Bro | ooklyr | Parl | k, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICEN | C a | / | | DADDRESS OF FAC | ck Funera: | Home | , | |
| l ou 2- | Chavy | | | | | | | e, MD 21061 |
| 23. PART I. Enter the diseases, or con shock, or heart failure. Lit | nplications that caused | the deeth. Do not | enter the mo | de of dying, auch | as cardiec or ree | piratory arr | eat, | Approximate |
| IMMEDIATE CAUSE (Final | action and a contract of the c | 0501011100 | | | | | | intarval Between Onset and Death |
| disease or condition | Heute Mi | CONSEQUENCE OF): | heface | tur | | | | |
| | DUE TO (OR AS A | CONSEQUENCE OF): | 9-0. | | | | | |
| Sequentielly ilst conditions, b. | | CONSEQUENCE OF: | Tudes | u | | | | |
| If any, leading to immediata cause. Enter UNDERLYING | Acato | HIIII als | fie | | | | | |
| CAUSE (Diseese or Injury that initiated evente | The second of th | CONSEQUENCE OF): | | | | | | + |
| resulting in deeth) LAST | Chote | rupites | | | | | | |
| PART II. Other eignificent conditions | contributing to death by | ut not moulting in t | he wedstyles | | 2-41 41 110 | | | |
| 33.110.110 | John During to Geeth De | at not resulting in t | ne underlying | ceuse given in i | | RMED? | A | MAILABLE PRIOR TO |
| | | | | | 1 □ YES | 2 🙀 NO | | OMPLETION OF CAUSE OF DEATH? |
| DID TOBACCO USE CONTRI | PLITE TO CALISE OF | E DE ATH VEC | | LINICEDTAIN | | | 1 | ☐ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL | | 6. PLACE OF DEATH | | UNCERTAIN | | | | |
| | 109PITAL: | 0 | THER: | e 5 🗆 Reeldence (| Cher (Specific) | | | |
| 27. MANNER OF DEATH | 26e. DATE OF INJURY | 26b. TIME O | F 26c. INJ | URY AT | 28d. DESCRIBE HOW | INJURY OCC | URED | |
| 1 Netural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJURY | | PK? 'ES 2 NO | | | | |
| 3 Suicide 6 Could not be | 20s. PLACE OF INJURY building, atc. (Speci | — At home, farm, stree | et, factory, office | | 26t. LOCATION (Street City or Town, State | and Number | or Rural Rou | rte Number, |
| | | | | | | | | |
| 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA Description one) 2 MEDICAL EXAMINER: | AN: To the beet of my knowle On the beele of examination | | | | | | | and menner se stated. |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUM | | | | forith, Day, Year) |
| fatieth funces | reo | | | D2080 | 6 | ▶ Ø | 131/9 | 24 |
| 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEA | TH (ITEM 27) (Type, Pri | 7() | 01 - | 2 / | 2 | -1// | |
| PATRICK A TOR | NES, MP | | beity A | Ed Eld | ledoup, | MO | 424 | / |
| SEP 0 6 1994 | 32. REGISTRAR'S SIGNA | n- fundament | - | | | | | |

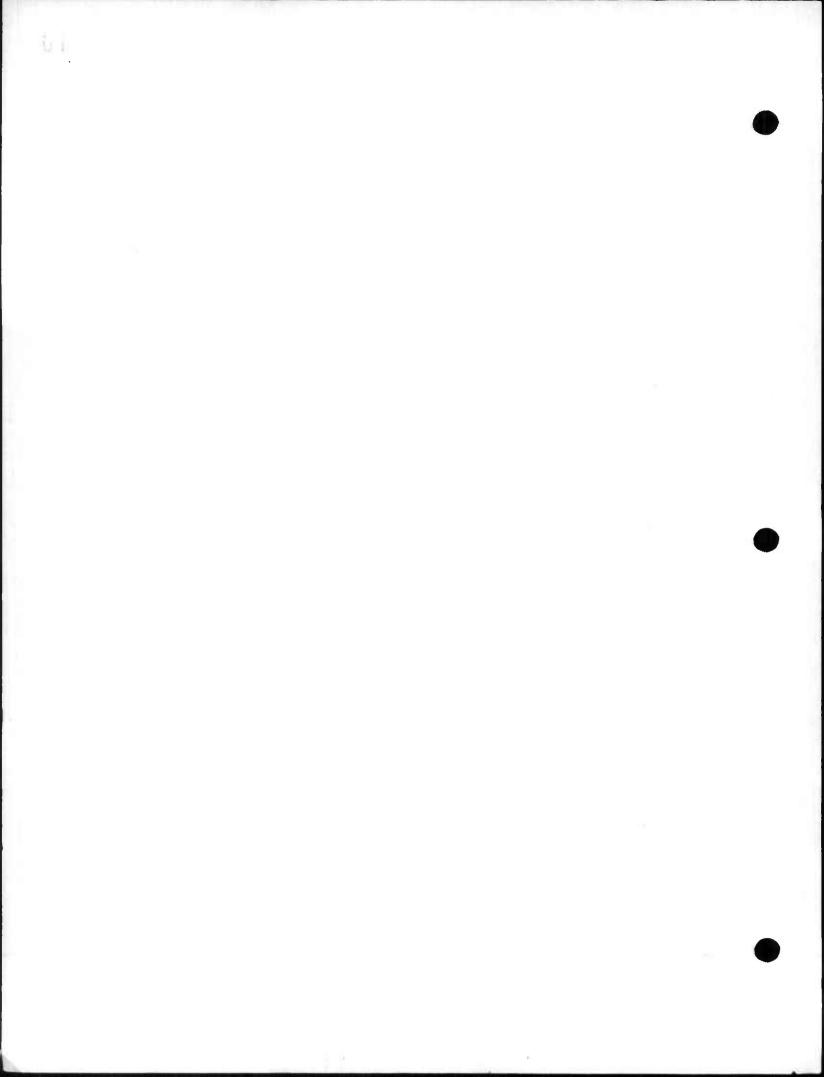
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS P.O. BOX 68760

| IDS, F.O. BOA 68/00, | TO THE MOSPITAL DR ATTRONONG PHYSICIAN: The law requires that the death certificate be executed within. Fours after death. Page 6 may be retained by the hospital or attending physician. | s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should thin State Dept, of Health and Mental Hygiene prior to buriat, cremation, or removal. | Injury, or other traumatic event, the medical examiner must be notified at once. |
|---|---|---|--|
| DIVISION OF VIEW HECONDS, F.O. BOX 66/60, | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be flied within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | FOR 1 - STATE REGISTRAR | STATE OF MAR | | | TMENT O | | | MENT | AL HYGIE | | | | |
|------------------|--|---|-----------------|-------------|--|---------------|-------------------------------------|------------|--------------------------------|---------------|-------------------|--|---------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) Gertrude L. | | GIBS | | | | | | TE OF DEATH | DAY | YEAR | 3. TIME OF OEAT | н |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 8. A | | | IF UNDER 1 YE | -48 | IF UNDER 24 HRS. | 9- | | l – ! | 94 | 11:50 | Рм |
| | 219 16 3354 | 1 M 2 TF | 85 (In yrs. las | YRS. | | \rightarrow | HOURS MIN. | 6 <u>m</u> | TOPO P | | Count | PLACE (State or Fo | reign |
| | 9a. FACILITY NAME (If not institution, give st | | | | 9b. CITY, TO | WN OR | LOCATION OF DE | ATH | | 9c. COI | UNTY OF D | | $\neg \neg$ |
| TOR R | Franklin Square | Hospital | | | Ess | sex, | /Roseda1 | e | | Ba | ltimo | re | 19 |
| DIRECTOR | 10e. STATE 10b. COUNTY | | | 10c. CITY | , TOWN OR L | OCATIO | ON | | | | | 10d. INSIDE CITY | |
| | Maryland Balt | imore Count | у | Es | sex | _ | | | | | | 1 YES 2 | NO |
| RA | 1000 Franklin A | venue | | | | 101. | 21221 | | | 10g. Cl | TIZEN OF V USA | VHAT COUNTRY? | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVE | | | | | NDENT OF HISPAN | | | res or No— | 14. RACE | - American India | in, |
| BYF | 1 Never Married 2 Merried 3 Wildowed 4 Divorced | FORCES? 1 Y | | No | | | offy Cuban, Mexical D NO Specify | | to Rican, atc.) | | Spec | k, White, etc. | |
| - 4 | 15. DECEDENT'S EDUC (Specify only highest grade | | | | USUAL OCCU | | | 1 | 6b. KINO OF E | USINESS/IN | IDUSTRY | | |
| COMPLETED | Elementary/Spcondary (0-12) | College (1-4 or 5+) | Hfe. | Do NOT us | rork done durin e retired.) ionist | | or working | | Insura | nco | | | |
| P P | 17. FATHER'S NAME (First, Middle, Last) | | | .ccp c | LONIES | | 18. MOTHER'S NA | | | | | | |
| BE C | Herbert Dear | | | | | | Louise | | | | | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) Ms Caroline Duora | ak | 196 | b. MAILING | ADDRESS (St | treet and | d Number or Aural F | Route Nu | imber, City or T | own, State, Z | (ip Code) | | |
| | 20a. METHOD OF DISPOSITION | | 20b. PLACE | AND DATE O | F DISPOSITIO | N (Nam | ne of | D | ATE 20c. I | OCATION - | - City or To | rwn, State | |
| | 1 Burlet 2 Cremelton 3 Remo | | cemetery, cre | 7.1 | | | | 1 | | | | 1925 | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEERonald W | ade,D | ir | | | ADDRESS OF FA | | | | | | |
| _ | Junian/1 | Made | | | | | V.Baltim | | | | | 01 | |
| | 23. PART I. Enter the disesses, or c shock, or heert fellure. I IMMEDIATE CAUSE (Finel disesse or condition | List Dniy Dne ceuse D | n esch line |). | ot enter the | e moa | e or dying, auci | n aa c | erdiec or rea | piratory a | rreat, | Approximation interval Be Onset and | etween |
| | resulting in death) | BOWel Ob | | | 7): | | | | | | | | |
| z | Sequentially list conditions, | Chronic | | | | ıken | nia | | | | | | |
| ATIC | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR A | S A CONSEC | DUENCE OF | "): | | | | | | | | |
| | CAUSE (Diseese or injury that initiated events | DUE TO (OR A | S A CONSE | DUENCE OF |): | | | | | | | | |
| CERTIFICATION | reaulting in death) LAST | f | | | | | | | | | | | |
| A. | PART II. Other aignificent condition | | | | | | | | | N AUTOPSY | 24b | . WERE AUTOPSY FI | |
| PHYSICIAN: MEDIC | Congestive hear | | cor, | onar | y arte | ery | disease | : | 1 🗌 YES | 2 📉 NO | | COMPLETION OF CO | AUSE |
| ¥ . | Tellal lallule | , | | | | | | | | | | 1 YES 2 1 | 40 |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HORBITAL | | | | 28. PLA | CE OF DEATH (Che | eck only | one) | | | | |
| KS | 1 TYES 2 XNO | HOSPITAL: | | | | - | 5 🗆 Residence | | | | | | |
| | 27. MANNER OF CEATH 1 X Netural 5 Pending | (Month, Day, Yea | | 28b. TIMI | URY | WOR | K? | 28d. C | ESCRIBE HOV | O YRULMI V | CCURED | | |
| D BY | 2 Accident Investigation 3 Suicide 8 Could not be | 28e. PLACE OF INJI building, etc. (5 | JRY — At ho | me, ferm, s | | | | | OCATION (Streetly or Town, Sta | | er or Rural I | Route Number, | $\overline{}$ |
| ETE | 4 Homicide determined | | | | | | | | | | | | |
| COMPLET | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC One) 2 MEDICAL EXAMINED | | | | | | | | | | | N | I |
| - 11 | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | n, in my opini | _ | 29c. LICENSE NUN | | ate end prace, | | | (Month, Day, Year) | uned. |
| TO BE | martinfal | rut mo | | | | | n/a | | | • | 9/2 | 194 | |
| - | 30. NAME AND ADDRESS OF PERSON WHO | | | | | , D. | | | morc | MD 21 | ל כי כי ו | | |
| | Martin Roberts 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S S | IGNATURE | | Square | : ע | rive pa | 1111 | more, | נוט עוז | 123/ | | \dashv |
| | SEP 0 6 1994 | Jalin Danden | Rulas | ٨_ | | | | | | | | | |



REG. NO.

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First Middle Lest)

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2. DATE OF DEATH DAY 3. TIME OF DEATH Roswell Ward Gilbert September 1994 5:30 P.M 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH
(Month, Day, Year)
July 21,1909 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign DAYS 136-09-9654 1 XM 2 - F 85 New York 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF CEATH DIRECTOR 8011 Strauff Road Pages 1, 2, 3 Riderwood Baltimore County RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore County Riderwood 1 - YES 2 X NO permit FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8011 Strauff Road funeral director, page 5 should be detached for use as the burial-transit 21204 U.S.A. retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No-it yes, specify Cuben, Maxican, Puerto Rican, stc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Married 2 Married 8 1 YES 2 NO Specify 3 X Widowed 4 Divorced White 16e. DECEDENT'S USUAL OCCUPATION ETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 5+ Electrical Engineer Defense Contracting 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surr To Roswell Ward Gilbert Martha Bradt Jones BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Martha G. Moran 8011 Strauff Rd. Riderwood, Maryland 21204 after death. Page 6 may be by the funeral director, page 9 20c. LOCATION — City or Town, State DATE must Green Mount Cemetery September 5 4 Donetion 5 Other (Specify) Baltimore, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home John G. Reitz (M-00804) 6500 York Rd. Baltimore, Maryland 21212 medical 23. PART I. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cardiec or raspiratory arrest, shock, or haart failure. List only one cause on each line. filled in by Approximete ō **IMMEDIATE CAUSE (Final** Onset and Death cremation. the disesse or condition_ rostak (94 Cer completely resulting in death) event. DUE TO (OR AS A CONSEQUENCE OF) and com o buriat. executed traumatic CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): nding physician a Hygiene prior to 2 If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 signed by the atte PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL any COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? Shows 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | has b Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h **EXAMINER?** OTHER: 1 - YES 2 X NO 1 Inpatient 2 ER/Outpatient 3 DOA ne 5 X Residence 10 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED this (marked, 1 X Natural 5 Pending investigation 1 YES 2 NO 8 After 2 Accident
3 Suicide OR ATTENDING 28a. PLACE OF INJURY — At home, term, street, factory, offica building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED DIRECTOR: Journal of the Communication of the Commu 4 Homicide 29a. CERTIFIER (Check only 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, end due to the cause(s) and menner as stated. HOSPITAL FUNERAL within 72 h 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: 1 296. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE (reme) MD 037016 9/6/94 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 7801 York Kd., Sect 101 erneth Greene Tous-2/204 32. REGISTRAR'S SIGNATURE Daniem-Randall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

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| DIVISION OF | |
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| VITAL RECORDS, P.O. BOX 68760, A BALTIMORE, MARYLAND 21215-0020 | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with ours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| DIVISION OF VITAL RECORDS, P.O | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certi | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending be filed within 72 hours after death with the State Dept. of Health and Mental Hygie | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or oti |

| 1. DECEDENT'S NAME (First, Middle, Last |) | | | | | 2. DATE OF DEATH | | | 3. TIME OF DEATH |
|--|--|--|--|--|--|--|--|--|--|
| Lillian Man | cy | Glessn | ner | | | September 1 | | YEAR OOL | 9:15 m |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. | | IF UNDER 1 YEA | R IF UNDER 24 HRS. | 7. DATE OF BIRTH | | B. BIRTHP | LACE (State or Foreign |
| 040-07-0758 | 1 □ M 2 🕅 F | 79 | YRS. | MONTHS DAY | HOURS MIN. | April 4 | 1915 | Contry | necticut |
| 9a. FACILITY NAME (If not institution, give | | | | 9b. CITY, TOW | N OR LOCATION OF I | | 9c. COUNT | | |
| Good Samaritan H | ospital | | | Baltir | nore | | N/A | | |
| RESIDENCE OF DECEDENT | | | | | | | 11/11 | | |
| | TY. | | | Y, TOWN OR LO | CATION | | | | 10d. INSIDE CITY LIMITS? |
| Maryland N/A | | | Bal | timore | | 0.77 | | | 1 X YES 2 NO |
| 10e. STREET AND NUMBER | | | | | 101. ZIP CODE | | | | HAT COUNTRY? |
| 914 E. Belvedere | | | | | 21212 | | | | States |
| 11. MARITAL STATUS 1 Never Married 2 Married | | 1 YES 2 | ARMED NO | If yes, | specify Cuben, Maxic | NIC ORIGIN? (Specify Year, Puerto Rican, etc.) | a or No 1 | 14. RACE Black, | - American Indian, Whife, etc. |
| 3 Widowed 4 Divorced | IF YES, GIVE | WAR OR DATES | | 1 🗆 1 | ES 2 X NO Spec | Hy: | | Specify | White |
| 15. DECEDENT'S ED | UCATION | 160 | DECEDENT'S | USUAL OCCUP | TION | 16b. KIND OF BU | ISINESS/INDII | ETRY | WIITE |
| (Specify only highest gra | de completed) | | (Give kind of w | vork done durina | most of working | 100. KIND OF BO | SINESS/INDU | SINT | |
| Elementary/Secondary (0-12) | College (1-4 or 5 | (+) | memake | | | Own Hor | ma | | |
| 17. FATHER'S NAME (First, Middle, Lest) | | 110 | Michigan | | 18 MOTHER'S N | AME (First, Middle, Maider | | - | |
| John Preiss | | | | | Nellie | | 1 Sarriame) | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | 19b. MAILING | ADDRESS /Stra | | Route Number, City or Tox | un State 7in f | Cordel | |
| Rudolf I. Glessne | or | | | | | nue Baltimo | | | 212 |
| 20a. METHOD OF DISPOSITION | | | | FDISPOSITION | | | OCATION - CI | | |
| 1 Buriel 2 Cremation 3 Re 4 Donation 8 Other (Specify) | moval from Stata | cemetary | crematory or of | herplaca) Cameter | 57 | 9/7/94 Wes | | | |
| 21. SIGNATURE OF FUNERAL SERVICE | ICENCES - | _ DC. II | EWILANE | | | | ot nav | en, | CI |
| | CICEIAGES - | 2011 | | 22. NAME | AND ADDRESS OF F | ACILITY | | | |
| | 1116 | 3/1/2/ | 5 | | | | e, Inc | | |
| John G. Reit | This | 3Hal | 2 | Mitc 6500 | hell-Wied York Ros | defeld Home ad Baltimon | e, Inc ce, MD | 212 | 212 |
| John G. Reit | simplications th | at caused the | death. Do n | Mitc 6500 | hell-Wied York Ros | defeld Home ad Baltimon | e, Inc re, MD | 212 et, | Approximate |
| John G. Re 23. PART I. Enter the diseases, o shock, or heart failure IMMEDIATE CAUSE (Final | simplications th | at caused the | death. Do n | Mitc 6500 | hell-Wied York Ros | defeld Home ad Baltimon | e, Inc ce, MD plratory arre- | 212 st, | |
| John G. Re 23. PART I. Enter the diseases, o shock, or heart failur IMMEDIATE CAUSE (Final disease or condition | simplications th | iuse on each ii | Ine. | Mitc 6500 not enter the | hell-Wied York Ros | defeld Home ad Baltimon | e, Inc ce, MD phratory arre- | 212 st, | Approximate interval Betwee Onset and Dear |
| John G. Re 23. PART I. Enter the diseases, o shock, or heart failure IMMEDIATE CAUSE (Final | complications the list only one ca | iuse on each ii | _{lar eve} | Mitc 6500 not enter the | hell-Wied York Ros | defeld Home ad Baltimon | e, Inc ce, MD piratory arre- | 212 st, | Approximate interval Between |
| John G. Rei | a. Cerebr | COVASCUI | Ine. Lar eve SEOUENCE OF | Mitc 6500 and enter the ment | hell-Wied York Ros | defeld Home ad Baltimon | e, Inc ce, MD | 212 et, | Approximate interval Betwee Onset and Dear |
| John G. Re 23. PART I. Enter the diseases, or shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate | a. Cerebr | COVASCUIO (OR AS A CONS | Ine. Lar eve SEOUENCE OF | Mitc 6500 and enter the ment | hell-Wied York Ros | defeld Home ad Baltimon | e, Inc ce, MD | 212 et, | Approximate interval Betwee Onset and Dea 30 minute |
| John G. Re 23. PART I. Enter the diseases, o shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, | a. Cerebrous Tour Tour Tour Tour Tour Tour Tour Tour | COVASCUI O (OR AS A CONS | LAT EVE SEQUENCE OF | Mitc 6500 not enter the | hell-Wied York Ros | defeld Home ad Baltimon | e, Inc ce, MD | 212 et, | Approximate interval Betwee Onset and Dea 30 minute |
| John G. Re 23. PART I. Enter the diseases, o shock, or heart failure immediate cause or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | a. Cerebrous Tour Tour Tour Tour Tour Tour Tour Tour | COVASCUI | LAT EVE SEQUENCE OF | Mitc 6500 not enter the | hell-Wied York Ros | defeld Home ad Baltimon | e, Inc ce, MD | 212 et, | Approximate interval Betwee Onset and Dea 30 minute |
| John G. Rei | a. Cerebrous Tour Tour Tour Tour Tour Tour Tour Tour | COVASCUI O (OR AS A CONS | LAT EVE SEQUENCE OF | Mitc 6500 not enter the | hell-Wied York Ros | defeld Home ad Baltimon | e, Inc ce, MD | *212 | Approximate interval Betwee Onset and Dea 30 minute |
| John G. Re 23. PART I. Enter the diseases, o shock, or heart failure immediate cause or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | a. Cerebrous Tour Tour Tour Tour Tour Tour Tour Tour | COVASCUI O (OR AS A CONS O (OR AS A CONS O (OR AS A CONS | Ine. LAT EVE SEQUENCE OF | Mitc 6500 oot enter the | he11-Wiec York Ros mode of dying, eu | defeld Home ad Baltimon ch as cardiac or resp | olratory arre- | st, | Approximate interval Betwee Onset and Dea 30 minute |
| John G. Rei 23. PART I. Enter the diseases, o shock, or heart failure immediate cause or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other algnificant conditions. | a. Cerebr DUE TO DUE TO DUE TO C. DUE TO DOES CONTRIBUTING to | COVASCUI O (OR AS A CONS O (OR AS A CONS O (OR AS A CONS | Ine. LAT EVE SEQUENCE OF | Mitc 6500 oot enter the | he11-Wiec York Ros mode of dying, eu | defeld Home ad Baltimon ch as cardiac or response to the part I. 24s. WAS AL PERFO | N AUTOPSY RMED? | st, 24b. | Approximate interval Betwee Onset and Dea 30 minutes 5 days |
| John G. Re 23. PART I. Enter the disease, o shock, or heart failure immediate. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST | a. Cerebr DUE TO DUE TO DUE TO C. DUE TO DOES CONTRIBUTING to | COVASCUI O (OR AS A CONS O (OR AS A CONS O (OR AS A CONS | Ine. LAT EVE SEQUENCE OF | Mitc 6500 oot enter the | he11-Wiec York Ros mode of dying, eu | defeld Home ad Baltimon ch as cardiac or response or r | N AUTOPSY RMED? | 24b. | Approximate interval Betwee Onset and Dea 30 minute: 5 days were autopsy finding Mailable Prior of Completion of Cause of Death? |
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| John G. Rei 23. PART I. Enter the diseases, o shock, or heart failure immediate cause or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other algnificant conditions, if any leading in death) LAST | a. Cerebr DUE TO DUE TO DUE TO C. DUE TO DOES CONTRIBUTING to | COVASCUI O (OR AS A CONS O (OR AS A CONS O (OR AS A CONS | Ine. LAT EVE SEQUENCE OF | Mitc 6500 not enter the | he11-Wiec York Ros node of dying, eu | defeld Home ad Baltimon ch as cardisc or response part I. 24s. WAS AL PERFO | N AUTOPSY RMED? | 24b. | Approximate interval Betwee Onset and Dea 30 minute: 5 days were autopsy finding Mailable Prior of Completion of Cause of Death? |
| John G. Rei 23. PART I. Enter the diseases, o shock, or heart failure immediate cause or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other algnificant conditions, if any leading in death last initiated eventa resulting in death). | a. Cerebres Due To Due To Diabetes | COVASCUI O (OR AS A CONS O desth but no | LAT EVE SEQUENCE OF SEQUENCE OF SEQUENCE OF | Mitc 6500 oot enter the ent | he11-Wiec York Ros mode of dying, au | n Part I. 24a. WAS AI PERFO | N AUTOPSY RMED? | 24b. | Approximate interval Betwee Onset and Dea 30 minute: 5 days were autopsy finding Mailable Prior of Completion of Cause of Death? |
| John G. Re 23. PART I. Enter the disease, o shock, or heart failure immediate cause or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other algnificant conditions in the condition of the condition | Cerebres Due To Diabetes HOSPITAL: 1 X Inpatient 2 | OVASCU O (OR AS A CONS O (OR AS A CONS O (OR AS A CONS O death but no | SEQUENCE OF | Mitc 6500 oot enter the ent | the 11-Wiece York Rose Mode of dying, au ring cause given in | n Part I. 24a. WAS AL PERFO 1 YES | N AUTOPSY RMED? | 24b. | Approximate interval Betwee Onset and Dea 30 minute: 5 days were autopsy finding Mailable Prior of Completion of Cause of Death? |
| John G. Rei 23. PART I. Enter the diseases, o shock, or heart failure immediate cause or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other algnificant conditions, if any leading in death last initiated eventa resulting in death). | Cerebrous Tour Tour Tour Tour Tour Tour Tour Tour | OVASCU O (OR AS A CONS O (OR AS A CONS O (OR AS A CONS O death but no | SEQUENCE OF SEQUENCE OF SEQUENCE OF SEQUENCE OF SEQUENCE OF | Mitc 6500 oot enter the sent 7): The sent 1 of 1 o | ting cause given in PLACE OF DEATH (Come 5 Residence work? | n Part I. 24a. WAS AI PERFO | N AUTOPSY RMED? | 24b. | Approximate interval Betwee Onset and Dea 30 minute: 5 days were autopsy finding Mailable Prior of Completion of Cause of Death? |
| John G. Re 23. PART I. Enter the disease, a shock, or heart failure importance in the disease of a shock, or heart failure importance in the disease or condition in the disease or condition in the disease or conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other algnificant conditions in the disease of the dise | Cerebra Due To Diabetes HOSPITAL: 1 X Inputations the List only one can be contributing to Diabetes 28a. DATE O (Month.) | OVASCU O (OR AS A CONS O (OR A | SEQUENCE OF | Mitc 6500 oot enter the sent 7): The sent 1 control of the sent 1 | he11-Wiec York Ros mode of dying, au ring cause given in PLACE OF DEATH (Come 5 Residence injury at WORK? YES 2 NO | n Part I. 24a. WAS AL PERFO 1 YES heck only one) 28d. DESCRIBE HOW | N AUTOPSY RMEO? 2 XNO | 24b. | Approximate interval Betwee Onset and Dea 30 minute: 5 days Were autopsy finding Amailable Prior to Completion of Cause of Death? 1 Yes 2 No |
| John G. Re 23. PART I. Enter the diseases, o shock, or heart failure immediate cause or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other algnificant conditions in the condition of the conditio | Cerebrose Sepsis DUE TO B. Sepsis DUE TO C. DUE TO DIA | COVASCU O (OR AS A CONS O desth but no | SEQUENCE OF | Mitc 6500 oot enter the sent 7): The sent 1 control of the sent 1 | he11-Wiec York Ros mode of dying, au ring cause given in PLACE OF DEATH (Come 5 Residence injury at WORK? YES 2 NO | n Part I. 24a. WAS AL PERFO 1 YES | N AUTOPSY RMED? 2 [XNO | 24b. | Approximate interval Betwee Onset and Dea 30 minute: 5 days Were autopsy finding Amailable Prior to Completion of Cause of Death? 1 Yes 2 No |
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| John G. Re 23. PART I. Enter the disease, a shock, or heart failure immediate. Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other algnificant conditions. Hypertension, 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 XNO 27. MANNER OF DEATH 1 XNstural 5 Pending Investigation in the distance of the properties of the properties in the proper | Cerebra Due To D | DOVASCU O (OR AS A CONS O (OR | LAT EVES SEQUENCE OF INVESTIGATION OF SEQUENCE OF INVESTIGATION OF SEQUENCE OF | Mitco 6500 oot enter the sent Fig. Fig. Fig. Fig. Fig. Fig. Fig. Fig. | PLACE OF DEATH (Come 5 Residence INJURY AT WORK? YES 2 NO Wife and place, and due to death occurred at the course of the cours | n Part I. 24a. WAS AI PERFO 1 YES heck only one) 28d. LOCATION (Street City or Town, Street at to the cause(a) and mae time, data and placa, a simble R 1 (9 | N AUTOPSY RMED? 2 (XNO INJURY OCCU and Number of | 24b. 24b. 24b. Cause(a) Signed (ptem | Approximate interval Betwee Onset and Dea 30 minute 5 days 5 days Were autopsy finding Malable Prior To Completion of Cause of Death? 1 Yes 2 No Number, and manner as stated. Month. Day. Vear) |
| John G. Re 23. PART I. Enter the disease, a shock, or heart failure importance cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other algnificant conditions in the condition of the condition | Cerebra Due To D | DOVASCU O (OR AS A CONS O (OR | LAT EVES SEQUENCE OF INVESTIGATION OF SEQUENCE OF INVESTIGATION OF SEQUENCE OF | Mitco 6500 oot enter the sent Fig. Fig. Fig. Fig. Fig. Fig. Fig. Fig. | PLACE OF DEATH (Come 5 Residence INJURY AT WORK? YES 2 NO Wife and place, and due to death occurred at the course of the cours | n Part I. 24a. WAS AI PERFO 1 YES heck only one) 28d. LOCATION (Street City or Town, Street at to the cause(a) and mae time, data and placa, a simble R 1 (9 | N AUTOPSY RMED? 2 (XNO INJURY OCCU and Number of | 24b. 24b. 24b. Cause(a) Signed (ptem | Approximate interval Betwee Onset and Dea 30 minute 5 days 5 days Were autopsy finding Malable Prior To Completion of Cause of Death? 1 Yes 2 No Number, and manner as stated. Month. Day. Vear) |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Anours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| _ | REGISTRAR | | CERTIF | ICATE OF | DEATH | REG. NO |). | | |
|---------------|--|--|--|--|-----------------------------------|---|--------------------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) MARY GUNTH | ER | | | | 2. DATE OF DEATH ON | av VEAR | 3. TIME OF DEATN 2:40 p M | |
| | 4. SOCIAL SECURITY NUMBER 215-24-9987 | 5. SEX 1 M 2 F | 6. AGE (In yrs. lest birthday) 9.2 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) March23 | 8. BIRTI Count | NPLACE (State or Foreign | |
| | Sa. FACILITY NAME (If not institution, give : | street end number) | | 9b. CITY, TOWN | OR LOCATION OF D | | 9c. COUNTY OF I | | |
| DIRECTOR | Riverview Num | rsing Ce | entre Inc. | Ess | зех | | Ва | 1timore | |
| Di l | 10e. STATE 10b. COUNT | Υ | 10c. CIT | Y, TOWN OR LOCAT | LOCATION 10d. INSIDE CITY LIMITS? | | | | |
| | Md. Baltimore | | | | Baltimore | | | | |
| FUNERAL | 100. STREET AND NUMBER 509 S 47th | Street | | 10 | 21224 | | 10g. CITIZEN OF | | |
| | 11. MARITAL STATUS 1 Never Married 2 Merried | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE W | T EVER IN U.S. ARMED YES 2 NO | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: Specify: | | | E American Indian, k, White, etc. | | |
| ВУ | 3 🙀 Widowed 4 🗌 Divorced | 11 120, 0.12 | AN ON BAILS | 1012 | z Zuo spec | ny. | Spec | White | |
| ED | 15. DECEDENT'S EDU (Specify only highest grade | CATION COMPONENTS | 16a. DECEDENT'S | USUAL OCCUPATION | ON | 16b. KIND OF BU | SINESS/INDUSTRY | WILLE | |
| COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5 + |) Iffe. Do NOT us | se retired.) | st or working | 4 67 | | | |
| N | 17. FATHER'S NAME (First, Middle, Last) | | Hous | ewife | to MOTHER'S N | AME (First, Middle, Maiden | Summer! | | |
| | John Dorn | | | | | | === | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | 1 | 195. MAILING | ADDRESS (Street 4 | | POTEL CL Route Number, City or Tox | | | |
| 임 | Ronald Colema | n | 525 | | | | | Md. 21220 | |
| | 20e. METHOD OF DISPOSITION 1 SP Burlel 2 Cremation 3 Rem | | 20b. PLACE AND DATE | OF DISPOSITION (No | | | OCATION City or To | | |
| | 4 Donation 6 Other (Specify) | | Oak Law | | erv 9/ | 3/94 | Baltimo | re MD. | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | a / | | | | | | |
| | * KATEAN | 1/1/2 | . 1111 | | - | uneral H | | | |
| | 23. PART 1. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | List only one ceu | se on each line. | met enter the mo | da of dylng, su | the an cardiac or resp | elratory arreat, | A 21221 Approximate interval Batween Onset and Death | |
| 20 | Sequentially list conditions, | b | OR AS A CONSEQUENCE O | | | | | | |
| CATI | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | e | ON AS A CONSEQUENCE O | | | | | | |
| CERTIFICATION | that initiated events resulting in death) LAST | DUE TO | OR AS A CONSEQUENCE O | F): | | | | | |
| | DARY II Other electricas and district | | | | | 1 | | | |
| : MEDICAL | PART II. Other significant condition | | HSDIOM! | 1 o Pa | g cause given in | 1 Part I. 24e. WAS AN PERFO | RMED? | NERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES: 2 NO | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | 26 PI | ACE OF DEATH (C | heck only one) | | | |
| SC | EXAMINER? | HOSPITAL: | ER/Outpetient 3 DOA | OTHER: | | | | | |
| PHYSICIAN | 27. MANNER OF DEATH | 26e. DATE OF | INJURY 26b. TIM | E OF 28c. INJ | URY AT | 6 ☐ Other (Specify) 28d. DESCRIBE NOW | INJURY OCCURED | | |
| ВУ Р | 1 Statural 5 Pending Investigation | (Month, De | | M 1 🗆 | PRK? YES 2 NO | | | | |
| G | 3 Suicide 6 Could not be 4 Nomicide datermined | 28e. PLACE Of building, | F INJURY At home, farm, etc. (Specify) | street, factory, offic | • | 261. LOCATION (Street City or Town, Stele | end Number or Rural) | Route Number, | |
| OMPLET | 000) | | my knowledge, death occurr | | | | | s) end manner ee stated. | |
| E CO | 295. SIGNATURE AND WILE OF CERTIFIE | | | | 29c. LICENSE NU | | | (Month, Day, Year) | |
| m | - Walco | e un | 4 | | NU | 410021 | D 91 | 2/95 | |
| 5 | 30. NAME AND ADDRESS OF PERSON WI | O COMPLETED CAUS | SE OF DEATH (ITEM 27) (Type | , Print) | | 100 | (1 | 1 1 | |
| | 31. DATE FILED (MONTH, Day, 194/) | 32. REGISTRA | R'S SIGNATURE | | | | | | |
| | 31. DATE ELEP (MONTE 0 1994 | Their Dans | R'S SIGNATURE | | | | | | |

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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| NO L | After this certificate has been signed by the attending physician and | leath with the State Dept. of Health and Mental Hygiene prior to | i marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified |
| 100 | 166 | 65 | - |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH CARL N. 12:35 Goins 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last hirthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 💢 M 2 🗆 F 37 DAYS HOURS 220 - 64-0583 VDQ 3-9-5 BALTO -9a. FACILITY NAME (If not institution, give street and number) 95 CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Union Memorial - Extended CARE DIRECTOR Barrimore RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MM BALTIMORE CIT 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3410 VIRGINIA Ave 21215 U.S. A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—if yea, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 N NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO 1 Never Married 2 Married В Specify: 3 Widowed 4 Divorced BIACK COMPLETED 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) LABORER TH n/a 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Peter 6 UINS KATTIE LAWSON BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3851 MONTEREY RD, BALTIMORE C., 9 MD **JESSIE** GDINS 29a. METHOD OF DISPOSITION

1 N Burlal 2 Cremation 3 Ramoval from Stata 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State
RANDALLSTOWN, MD DATE CKNET NG MATOR MENTOR IAL PARK 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY C. MARCH FH.-1101 Ε. NORTH AV WM. 23. PART I Enter the diseases, or complications that/ceused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory errest, shock, or heard fellure. List only one ceuse on each line. Approximate interval Between IMMEDIATE CAUSE (Finel Onset and Death disease Dr condition_ Squamous cell curcinoma of hypophar DUNTO (OR AS A CONSPOUENCE OF): 12/93-10H resulting in death) PHYSICIAN: MEDICAL CERTIFICATION Sequentially liet conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PERFORMED? 1 YES ZONO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 VES 2 NO 28. PLACE OF DEATH (Check only one) OSPITAL: OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 5 Pending Investigation 1 Vetural М 1 YES 2 NO В 2 Accident 3 Suicide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Yown, State) CETED 8 Could not be 4 Homicide detarmined 29a. CERTIFIER

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

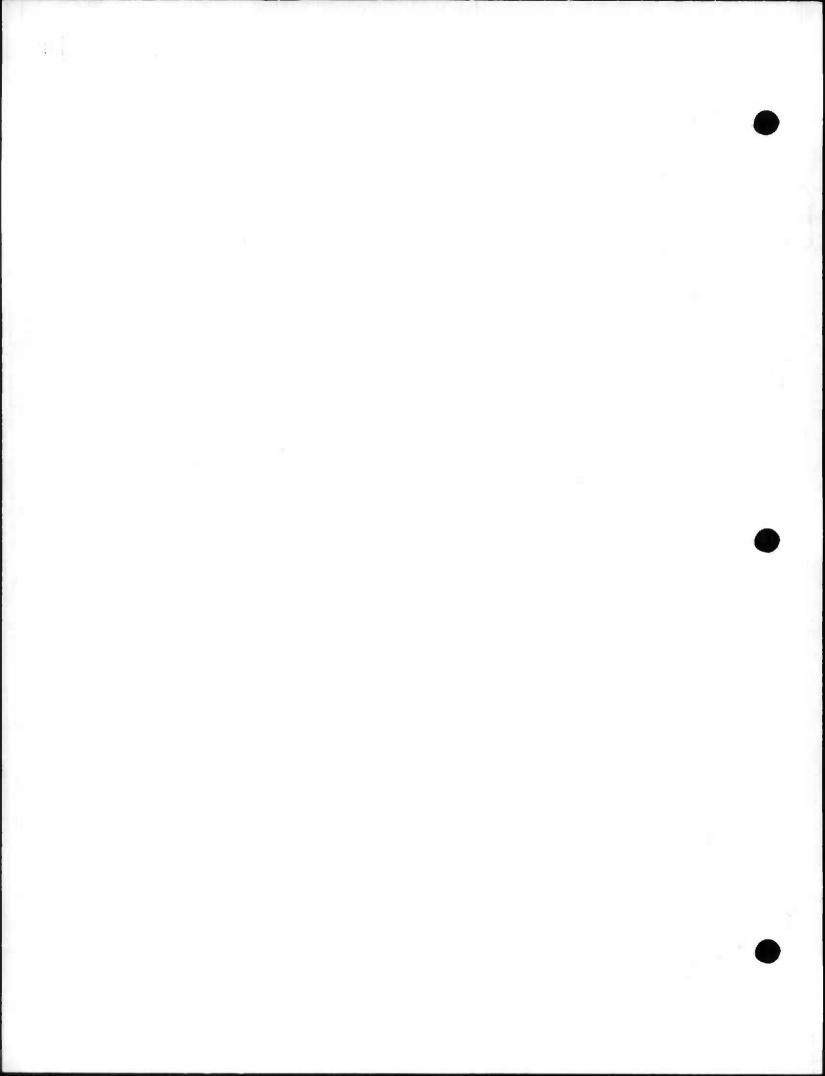
| Mary & Can MD | | September 03, |
|--|------------|---------------|
| NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dupt of Family Medium, 74 | 5. Pack St | Baltimere, Ma |

Medicine 29 3. Pack St tamily

32 REGISTRAR'S SIGNATURE SEP 06 1994

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BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with fours after death. Page 6 may be retained by the hospital or attending physician.

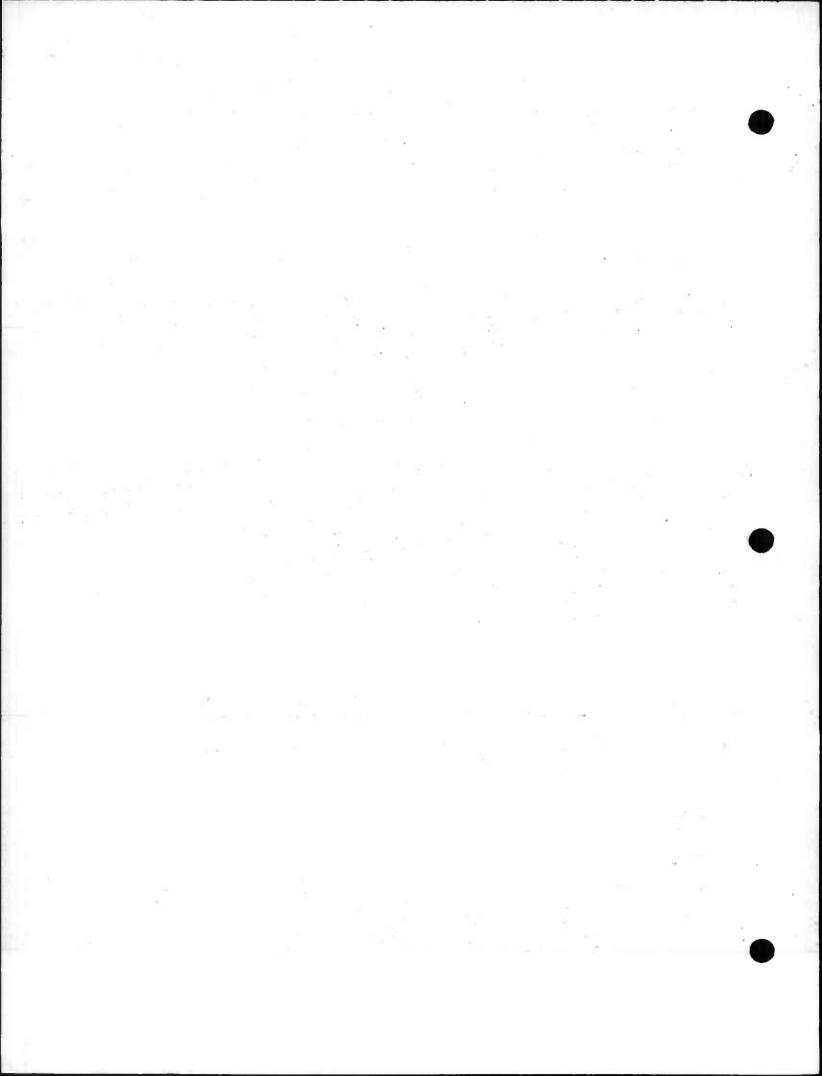
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notitied at once.

| | FOR | STATE OF MARYLAND | / DEPARTMEN | T OF HEALTH AND | MENTAL HYGIEN | | 20013 |
|-------------|--|--|---|---|---|------------------------|--|
| | 1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) | | | E OF DEATH | REG. NO | | 3. TIME OF DEATH |
| | Ruth Antoin | ette Gr | eene. | | MONTH S D | 26 OL | 2:00 P. |
| | 220-12-6446. | SEX 6. AGE (In yrs. | Ist birthday) IF UNDE | R 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8 6. BiF | TTHPLACE (State or Foreign intry) |
| TOR | 90. FACILITY NAME (If not institution, give street 14 W. CA SOF RESIDENCE OF DECEDENT | ing lane | 96. CIT BO | y, town or location of D | EATH / | 9c. COUNTY OF | P DEATH |
| DIRECTOR | 10a. STATE 10b. COUNTY | | 10c. CITY, TOWN | or LOCATION Himore | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| FUNERAL | 14 W. Cold Sor | ing Lane | | 21210 | | 10g. CITIZEN O | F WHAT COUNTRY? |
| BY FUR | 11. MARITAL STATUS 1 | WAS DECEDENT EVER IN U.S. FORCES? 1 TYES 2 IF YES, GIVE WAR OR DATES | ARMED 13. | WAS DECENDENT OF HISPA If yes, specify Cuban, Maxic 1 YES 2 NO Speci | nn, Puarlo Rican, etc.) | BI | ACE — American Indian, ack, White, alc. ecity: |
| COMPLETED | 15. DECEDENT'S EDUCATII (Specify only highest grade com Elementary/Secondary (0-12) | pleted) | DECEDENT'S USUAL (Give kind of work done life. Do NOT use retired.) | during most of working | 166. KIND OF BU | SINESS/INDUSTRY | , |
| | 17. FATHER'S NAME (First, Middle, Last) | ses Gra | eene | 18. MOTHER'S N. | AME (First, Middle, Maiden | | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) | Gister | | S (Street and Number or Rural | Route Number, City or Tow | on, State, Zip Code) | ore 21215 |
| | 20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Ramoval 4 Donation 5 Other (Specify) | | CE AND DATE OF DISPO crematory or other place | | DATE 20c. LO | OCATION — City or | Town, Stata |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENS | Repaid W | ode, DAC 22 | NAME AND ADDRESS OF FA | Himores | e Anat | to MD8120 |
| | 23. PART I. Enter the disease, or com shock, pr heert feilure. List IMMEDIATE CAUSE (Finel disease pr condition | plications that coused the pnly pne cause on each if | deeth. Do not ente | r the mode of dying, aud | ch as cardlec or reep | iratory arrest, | Approximate Interval Between Onset and Death |
| N | reculting in death) | DUE TO (OR AS A CON | SEOUENCE OF): | v actions | | | 1 un |
| RTIFICATION | Sequentielly list conditions, it eny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONS DUE TO (OR AS A CONS | c /40 | eart | | | 4 yrs |
| CER | PART II. Other algorificent conditions co | antributing to death but no | of seculting in the co | | Seat Les mais | | |
| MEDICAL | | | a coording in the c | | Pert i. 24s. WAS AN PERFOI | RMED? | 4b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| | 25. WAS CASE REFERRED TO MEDICAL | | | 26 BLACE OF DEATH (C | | | |
| SICIAN | EXAMINER? | OSPITAL: | 3 DOA A N | R: rsing Home 5 D Residence | | | |
| у РНУ | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 26a. DATE OF INJURY (Morith, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW | INJURY OCCURED | |
| ETED B | 3 Suicide 6 Could not be detarmined | 28s. PLACE OF INJURY — At building, atc. (Specify) | home, farm, street, tac | ctory, office | 26t. LOCATION (Street City or Town, State) | and Number or Run) | al Route Number, |
| OMPLET | | To the best of my knowledge, in the basis of examination and/ | | | | | e(a) and manner as stated. |
| O BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER | hen | | 29c. LICENSE NU | MBER (6/0) | 29d. DATE SIGN | ED (Month, Day, Year) |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

SEP 06 1994

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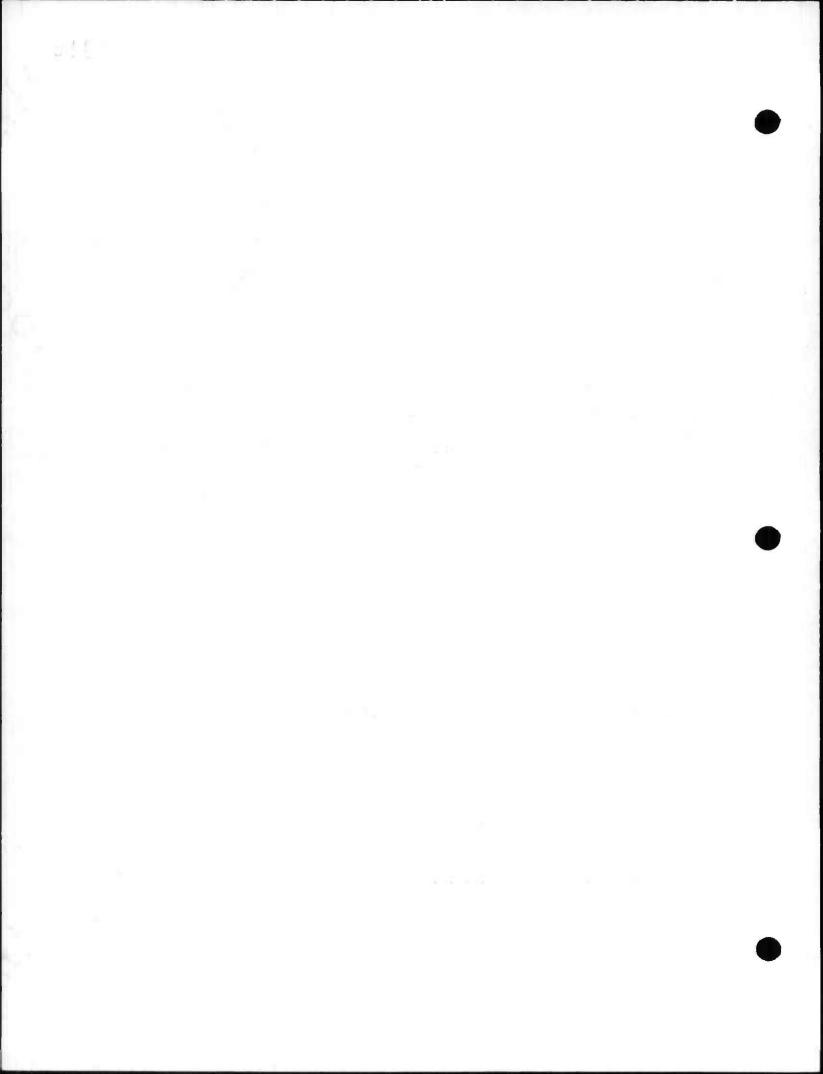
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE his Denden-Rudall

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO t. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Florence **Holmes** September 1994 11:20a M 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreig Country) JE UNDER 1 YEAR IF INDER 24 HRS 7. DATE OF BIRTH t - M 2 X DAYS HOURS 216-42-9288 87 August 13, Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number. 9h. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Meridian Perring Parkway N.H. Baltimore Baltimore RESIDENCE OF DECEDENT 10a. STATE tob. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Baltimore Baltimore 1 YES 2 X NO permit. 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1550 Sherwood Road use as the burial-transit 21212 United States retained by the hospital or attending physician. 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 ☐ YES 2 NO Specify: Specify: White BY 3 X Widowed 4 Divorced ETED 10e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Homemaker Own Home 17 FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) te Charles Frank Margaret Brown BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 Peter J. Holmes. RFD 2 Henry Road Danielson, Connecticut 06239 pe pe 20e. METHOD OF DISPOSITION

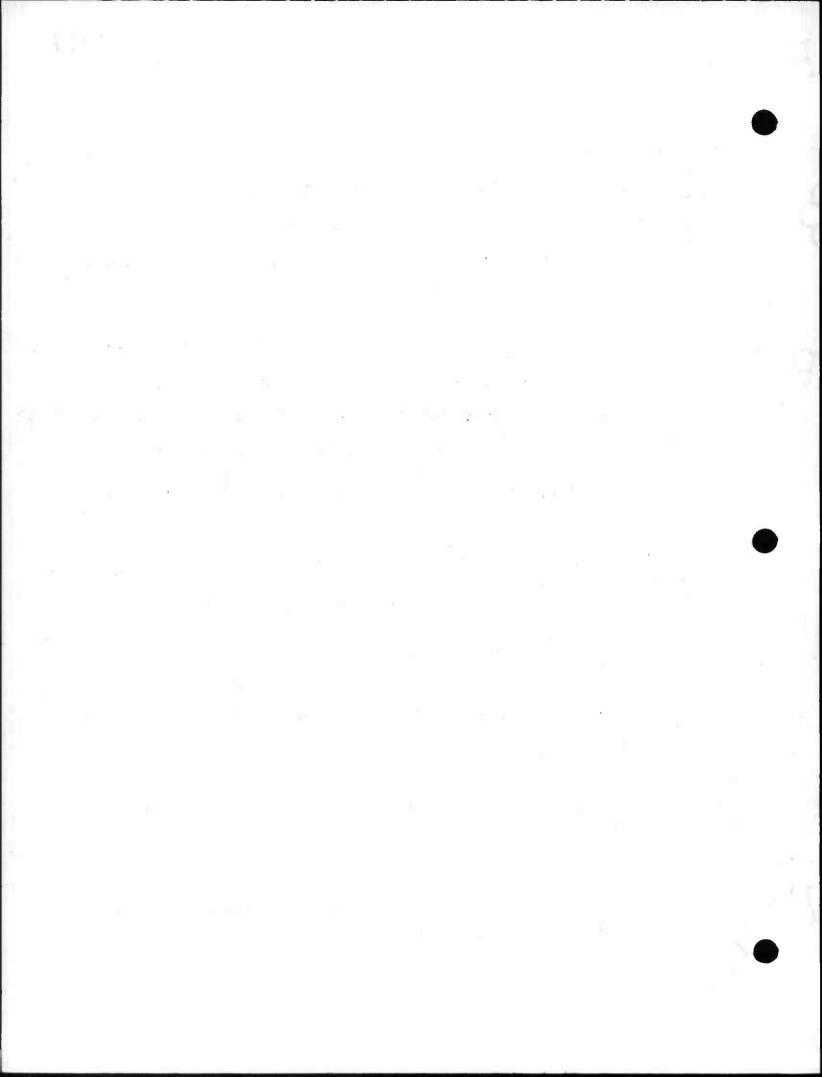
1 State | Second | S 20b. PLACE AND DATE OF DISPOSITION (Name of Page 6 may 20c. LOCATION — City or Town, State DATE must funeral director. St. Mary s Govans 09-94 4 Donation 5 Other (Specify) Baltimore, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY death. Mitchell-Wiedefeld Home John G. Reitz (M-00804 6500 York Rd. Baltimore, Maryland 21212 and completely filled in by the burial, cremation, or removal. hours after the medical Enter the diseases or complications that ceused the shock, or heart failure that only one ceuse on each line 23. PART I. Enter the disease Do not enter the mode of dying, such as cardiac or respiretory arrest, Interval Between IMMEDIATE CAUSE (Final Opisot and Death disease or condition resulting in death) ROW event, (OR AS A CONSEQUENCE OF) executed traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) 5 If any, laeding to immediata cause. Enter UNDERLYING attending physician 3 CAUSE (Disesse Dr Injury other DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in deeth) LAST 0 signed by the atte PART II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? that any 1 TYES 2 NO 1 YES 2 NO 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | PHYSICIAN: certificate has be the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OTHER: 1 | YES 2 | NO 1 Inpatient 2 ER/Outpatient 3 DOA 8 - Other (Specify) 6 the 27. MANNER OF DEATH 20a. DATE OF INJURY with 1 marked. 28b. TIME DE 20c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 Netural
2 Accident 5 Pending Investigation 1 YES 2 NO DIRECTOR: After the hours after death vitem 28 is mart BY ATTENDING 28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide OR 29s. CERTIFIER (Check only one) t CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as attated. TO THE HOSPITAL OF TO THE FUNERAL D be filed within 72 ho 2 MEDICAL EXAMINER: On the b on and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated. 296. SIGNATURE AND TITLE CHATIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE * Patricio, M.D.P.A. Gracito D08358 9/6/94



| DIMEION OF VITAL | CR CTENDING PHYSICIAN: The law | DIRECTOR Assettle certificate has b | your and done with the State Dept | ien 28 jamented, or item 23 |
|------------------|--------------------------------|-------------------------------------|-----------------------------------|-----------------------------|
| _ | TO THE HOSPITAL | TO THE FUNERAL | be filed within 72 | IMPORTANT: If |

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | . HYGIENE |
|---|-----------|
| CERTIFICATE OF DEATH | REG. NO. |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | MENT OF H | | MENTAL HYGIEN | | |
|----------------------|--|---|---|--|--|---|--------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | ELIZABETH | S. H | YATT | | 2. DATE OF DEATH MONTH 09-03 | | 3. TIME OF DEATH 1:42 P. M |
| 72 | 4. SOCIAL SECURITY NUMBER 214-26-8933 | 1 🗆 M 💥 💢 F | 90 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTN (Month, Day, Year) 07-16- | 8. BIR Cou | THPLACE (State or Foreign intry) NNSYLVANIA |
| TOR | 99. FACILITY NAME (If not institution, give a 3605 EDNO) RESIDENCE OF DECEDENT | | | | EMORE | CITY | 9c. COUNTY OF | DEATN |
| DIRECTOR | MARYLAND 10b. COUNTY | (| 10c. CITY | BALT | | CITY | | 10d. INSIDE CITY LIMITS? XX YES 2 \(\text{N} \) NO |
| FUNERAL | 100. STREET AND NUMBER 3605 EDNO | | | 101 | 2121 | 8 | -01 | S • A • |
| B | 11. MARITAL STATUS 1 Never Merried 2 Married XX Widowed 4 Divorced | 12, WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | | If yes, sp | ENDENT OF HISPAN acity Cuben, Mexica 2XXIO Specify | NC ORIGIN? (Specify Yein, Puerto Rican, etc.) | Sp | CE — American Indian, ack, White, atc. achy: WHITE |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | | life. Do NOT use | ndk done during mo | | 22.000.000 | ISINESS/INDUSTRY | |
| | 17. FATHER'S NAME (First, Middle, Last) WILI | | | | | ME (First, Middle, Maider NNAH SO | Sumame) | |
| TO BE | 19e. INFORMANT'S NAME (Type/Print) HANNAH L. HYAT' | r (DAUGHTER | | | | Route Number, City or Ton | | LAND 21218 |
| | 20s_METNOD OF DISPOSITION A Burlet 2 | ovel from State 20b | PLACE AND DATE O entery, crematory or off LEIDY | F DISPOSITION (Na | me of | DATE 20c. LC | OCATION — City of | Town, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE Park | 4 | 22. NAME AF | DADDRESS OF FA | JENKIN | S & S | SONS ,MD.21212 |
| | 23. PART i. Enter the diseases, or ahock, or heert failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | a | ach line. | tean | de of dying, auc | h aa cerdiac or reap | piratory arrest, | Approximata interval Between Onset and Death |
| CERTIFICATION | Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in desth) LAST | DUE TO (OR AS A | CONSEQUENCE OF | structi | 4 | n snary a | disease | 54rs |
| PHYSICIAN: MEDICAL C | PART II. Other significent condition | | | | | PERFO | RMED? | 4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| SICIAN | DID TOBACCO USE (25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES X NO | HOSPITAL: | | 26. PL OTHER: | ACE OF DEATH (Ch | - 4 | | |
| ВУ РНУ | 27. MANNER OF DEATN XX Natural 5 Pending 1 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME | OF 28c. INJ | | 28d. DESCRIBE HOW | INJURY OCCURED | |
| | 3 Suicide 8 Could not be 4 Nomicide determined | 28e. PLACE OF INJURY building, etc. (Spec | At home, ferm, st | ireet, fectory, offic | | 281. LOCATION (Street City or Town, State | end Number or Rurs | al Route Number, |
| COMPLETED | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | CIAN: To the best of my knowl R: On the beele of examination | ledge, death occurre | d at the time, data n, in my opinion, d | and place, end dua | to the cause(s) and ma | nner as stated. | e(e) and manner ee stated. |
| TO BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER | K Buch M | | | 29c, LICENSE NUM DZGC | ABER 120 | | ED (Month, Day, Year) -06-94 |
| - | JOYCE K. BURD | M.D.,2328 | WEST JO | | AD, LUTI | HERVILLE | , MARYLA | ND,21093 |
| | SFP 0 6 1994 | 32. REGISTRAR'S SIGN | ATURE | | | | | |



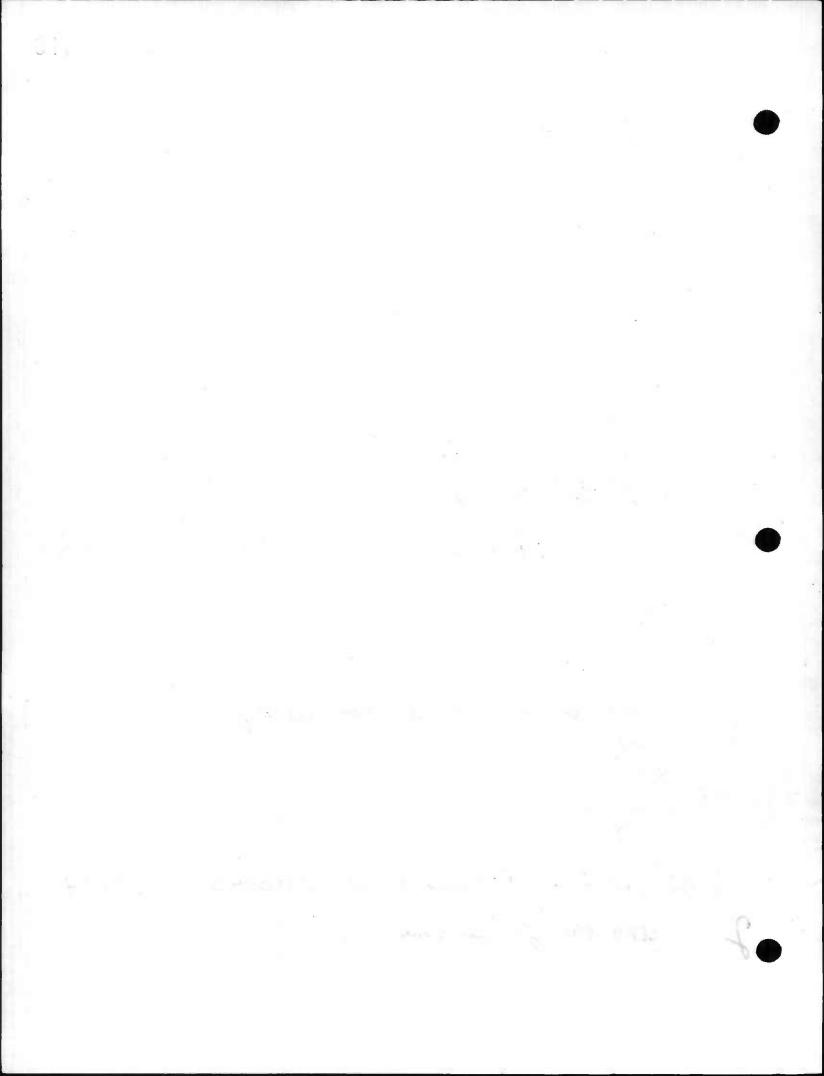
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and our ster death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buria-transit in

| | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND | MENTAL HYGIENE |
|---|--------------------------------------|--|----------------|
| | REGISTRAR | CERTIFICATE OF DEATH | REG. NO. |
| - | PECEDENT'S NAME (First Middle set) | | |

| | 1. DECEDENT'S NAME (First, Middle, Las | • | | | | | | 2. DATE OF DEATH DA | AY | YEAR | 3. TIME OF DEATH |
|------------------------------------|--|--|--|--|---|---|---|---|--|-------------------------------------|---|
| | RANDOLPH (NI | MN) HALL | | | | | | 8 27 | - 6 | 79 | + PM |
| | 212-88-6582 | 5. SEX 1X XM 2 - F | 8. AGE (In yrs. Is 34 | YRS. | MONTHS C | YEAR IF UNDE | R 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) 8-7-60 | | Country | PLACE (State or Foreig |
| OR | 99. FACILITY NAME (if not institution, give street and number) STELLA MARIS HOSPICE 96. CITY, TOWN OR LOCATION | | | | | | ION OF DEA | | | NTY OF DE | ATH |
| 5 | RESIDENCE OF DECEDENT | | | | | | | | | | |
| DIRECTOR | 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION BALTO | | | | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| FUNERAL | 100. STREET AND NUMBER 2924 RIDGEWOO | D AVE | | | | 101. ZIP COO | 215 | | 10g. CIT | U.S. | a . |
| BY | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE W | YES XX | | If y | | en, Maxican, | ORIGIN? (Specify Year Puerlo Ricen, stc.) | or No— | Black, | - American Indian, White, etc. |
| PLETED | 15. DECEDENT'S ET (Specify only highest gra Elementery/Secondary (0-12) 11TH | | (0 | ECEDENT'S Give kind of vie. Do NOT us WAIT | e retired.) | UPATION ing most of work | ing | 16b. KIND OF BUS | SINESS/INC | DUSTRY | |
| E COMPL | 17. FATHER'S NAME (First, Middle, Last) CLYDE HALL S | R. | | _ | | | | E (First, Middle, Maiden JDE WIDE | , | | |
| TO BE | 190. INFORMANT'S NAME (Type/Print) GERTRUDE HALL | | | | | | | ute Number, City or Town | | | 5 |
| | 20a. METHOD OF DISPOSITION | | 20b. PLACE | ANDDATE | OF DISPOSITI | | | | | City or Tow | |
| | 1 N Buriel 2 Cremation 3 Ra 4 Donation 5 Other (Specify) | movel from State | cemetery, cr | ZION | I CEM | ETERY | 9 | 394 LA | NSDC | WNE | , MD |
| | 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE | | | | ARCH | | VEST 430 | O WA | BASI | HAVE |
| FICATION | resulting in death) DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| EL. | resulting in deeth) LAST | | | | F): | | | | | | |
| CERTIFI | resulting in deeth) LAST | d | | | F): | · | | | | | |
| MEDICAL CERTIF | PART II. Other significent condition | | | | in the unde | | | PERFOR | MED? | | AMAILABLE PRIOR TO |
| : MEDICAL | PART II. Other significent condition | | | | In the unde | YES [|] NO\ | PERFOR | MED? | | AVAILABLE PRIOR TO COMPLETION OF CAU OF DEATH? |
| AN: MEDICAL | PART II. Other significent condition DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | CONTRIBUTE HOSPITAL: | TO CAU | SE OF | DEATH | YES 26. PLACE OF 6 | NO NEATH (Check | PERFOR | NO NO | | |
| Y PHYSICIAN: MEDICAL | PART II. Other significent condition DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending | CONTRIBUTE HOSPITAL: 1 Inpetient 2 28e. DATE OF (Month, D | ER/Outpatient | SE OF | DEATH OTHER: 4 Nursin | 26. PLACE OF E | NONDEATH (Check | PERFOR | Hosp | ice | AVAILABLE PRIOR TO COMPLETION OF CAU OF DEATH? |
| TED BY PHYSICIAN: MEDICAL | PART II. Other significent conditions DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | CONTRIBUTE HOSPITAL: 1 Inpetient 2 28e. DATE OF (Month, D) 26e. PLACE O | ER/Outpatient | SE OF | OTHER: 4 Nursin | 26. PLACE OF 1 g Home 5 R sc. INJURY AT WORK? 1 YES 2 | NO NO | PERFOR 1 YES 2 Vonly one) [XOther (Specify) | HOSP | rice | AMALABLE PRIOR TO COMPLETION DF CAU OF DEATH? 1 YES 2 NO |
| OMPLETED BY PHYSICIAN: MEDICAL | PART II. Other significent conditions of the con | CONTRIBUTE HOSPITAL: 1 Inpetient 2 28e. DATE OF (Month, D) 26e. PLACE O | ER/Outpatient ENJURY ay, 'bar') FINJURY — At hetc. (Specify) my knowledge, d | SE OF 3 DOA 28b. TIM INJ ome, farm, to | OTHER: 4 Nursing Mr. Street, fectory and st the time | 26. PLACE OF 6 g Home 5 R GC. INJURY AT WORK? 1 YES 2 (| DEATH (Check esidence 6 | PERFOR 1 YES 2 Conly one) (Cother (Specify) Red. DESCRIBE HOW II City or Town, State) | HOSP NJURY OC | iCe CURED | AMALABLE PRIOR TO COMPLETION OF CAU OF DEATH! 1 YES 2 NO |
| MPLETED BY PHYSICIAN: MEDICAL | PART II. Other significent conditions DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | CONTRIBUTE HOSPITAL: 1 Inpetient 2 28e. DATE OF (Month, D) 28e. PLACE O building, 7SICIAN: To the best of NER: On the best of eight | ER/Outpatient ER/Outpatient INJURY asy, Year) FINJURY — At h etc. (Specify) my knowledge, d xamination end/or | SE OF 3 DOA 28b. TIM INJ Ome, farm, to | DEATH OTHER: 4 Nursin E OF URY M street, fectory and at the time in, in my opin | 26. PLACE OF 8 g Home 5 R gC. INJURY AT WORK? 1 YES 2 [g, office | DEATH (Check esidence 6 | PERFOR 1 YES 2 Vonly one) (XOther (Specify) Red. DESCRIBE HOW II City or Town, State) the cause(e) end mer me, date end place, en | HOSP NJURY OC | ice CURED or Rural Ro ted. | AMALABLE PRIOR TO COMPLETION OF CAU OF DEATH! 1 YES 2 NO |
| BE COMPLETED BY PHYSICIAN: MEDICAL | PART II. Other significent conditions DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident a determined 2 Accident 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN | CONTRIBUTE HOSPITAL: 1 Inpetient 2 28e. DATE OF (Month, D) 26e. PLACE Of building, VSICIAN: To the best of NER: On the best of experience of experience of experience of the complete of the complete of experience of the complete o | ER/Outpatient ER/Outpatient FINJURY ay, Year) FINJURY — At h etc. (Specify) my knowledge, d xamination end/or | 3 DOA 28b. TIM INJ | DEATH OTHER: 4 Nursin E OF URY M street, fectory M Print) | YES | DEATH (Check esidence 6 NO 2 n, end due to red at the tir | PERFOR 1 YES 2 Vonly one) (XOther (Specify) Red. DESCRIBE HOW II City or Town, State) the cause(e) end mer me, date end place, en | HOSP NJURY OCI and Number there exists did due to the second seco | ice CURED or Rural Ro ted. | AMALABLE PRIOR TO COMPLETION DF CAI OF DEATH? 1 YES 2 NO |





DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours are the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours are the burial-transit permit. Or the the transition of the property of the pr | |
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| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPAR | RTMENT OF | HEALTH AND | MENTAL HYGIEN | | |
|--|---|---|--------------------------------------|--------------------------------|---|---|--------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Les DUANE | MICHAEL | | HICKS | | 2. DATE OF DEATH DO O O O | | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 215 - 54 - 2407 | 5. SEX 6. AGE (1 ☑ M 2 ☐ F 44 | in yrs. lest birthdey) YRS. | IF UNDER 1 YEAR MONTHS DAYS | | 7. DATE OF BIRTH (Month, Day, Year) $12 - 02 -$ | 8.1 | BIRTHPLACE (State or Foreign Country) MARYLAND |
| OR | 9m. FACILITY NAME (# not institution, giv 389 VALIANT CI | RCLE | | | OR LOCATION OF DE | EATH | 9c. COUNTY ANNE | of death ARUNDEL |
| DIRECTOR | 10a. STATE 10b. COUL MARYLAND ANNE | | | Y, TOWN OR LOC | | | | 10d. INSIDE CITY LIMITS? |
| FUNERAL C | 100. STREET AND NUMBER 389 VALIANT CI | | | | 101. ZIP CODE 21061 | | | 1 ☐ YES 2 XXNO OF WHAT COUNTRY? S.A. |
| BY FUNE | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR D. VIETNAM | 2 NO | If yes, | ECENDENT OF HISPAN specify Cuban, Maxica ES 2 (X NO Specify | | s or No- 14. | RACE — American Indian, Black, Whita, atc. Specify: WHITE |
| COMPLETED | 15. DECEDENT'S E (Specify only highest gra Elamentary/Secondary (0-12) 1.2 | DUCATION | IIIe. Do NOT u | work done during i | nost of working | 166. KIND OF BU | | RY |
| BE CON | | | | | | | | TIPTON |
| 2 | 19a. INFORMANT'S NAME (Type/Print) MRS. LINDA C. HI | | 389 VA | LIANT C | IRCLE, GL | EN BURNIE, | , MARYL | AND 21061 |
| | 20e. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Re 4 Donation 5 Other (Specify) | emoval from Stata | PLACE AND DATE etery, cremetory or o | VETERAN | CEMETERY | 1967 CROW | NSVILLI | or Town, Stata E, MARYLAND |
| | 21. SIGNATURE OF ELLIVERAL SERVICE | 2 ge Heek | 22 | | | ERAL HOME S.W.,GLEN | N BURNI | E, MD 21061 |
| | 23. PART I. Enter the diseases, of shock, or heart failur. IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. List only one cause on a | sch lina. | eR | node of dying, auc | h as cardiac or respi | Iratory arrest, | Approximate Interval Between Onset and Death |
| Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | |
| AL | PART II. Other significant condition | ona contributing to death be | ut not rasulting | in the underlyi | ng cause given in | Part I. 24s WAS AN PERFOR | RMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: MEDIC | DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL | | F DEATH YE | | | N D | | 1 - YES 2 - MO |
| IYSIC | EXAMINER? 1 YES 2 PRO 27. MANNER OF DEATH | HOSPITAL: | | | me 5 Mealdence | | | |
| in | 1 Netural 5 Pending Investigation | | | M 1 | AJURY AT YORK? YES 2 NO | 28d. DESCRIBE HOW II | | |
| Breo | 3 Suicide 8 Could not b 4 Homicide detarmined | bunding, att. (cpot) | (Y) | | | 281. LOCATION (Street a City or Town, State) | | ural Route Number, |
| COMPLETED | (Check only | SICIAN: To the best of my knowle | | | | | | use(a) and manner as stated. |
| TO BE | 29b. SIGNATURE AND TITLE OF CERTIF | \sim | | | O38Y | IBER O 9 | | 04-1994 |
| | DR. WILLIAM SHA | | EASTERN | | ALTIMORE, | MARYLAND | 2122 | 4 |
| | 31. SEP 0 6 1994 | Junio Dandon-Ra | | | | | | OMAM 12 Pay 1/00 |

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PWISION OF VITAL RECORDS, P.O. BOX 68760,

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| TO THE HIGHTOLL OR AT INDING PHYSICIAN: The law requires that the death certificate be executed within 24 fours after death. Page 6 may be retained by the hospital or attending | TO THE FUNDAL After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| | | FOR 1 STATE | STATE OF I | MARYLAND / | DEPAR | TMEN | T OF H | EALTH | AND N | MENTA | L HYGIEN | E | | |
| | | REGISTRAR | | | ERTIF | | | | | | REG. NO. | _ | | |
| 1 | 1 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | MONT | | | YEAR | TIME OF DEATH |
| | -1 | MARION 4. SOCIAL SECURITY NUMBER | CECII | | _ | AWO! | | | | | - 02 | | | 5:05 P M |
| | | 214 - 01 - 8719 | 5. SEX 1 ☐ M 2 💢 F | 6. AGE (In yrs. In: | YRS. | MONTHS | R 1 YEAR | IF UNDER | 24 HPIS. | (Mont) | OF BIFTH h, Day, Year) | | Country) | ACE (State or Foreign |
| | 1 | 9a. FACILITY NAME (If not institution, give s | | 04 | rno. | AL OUT | Y TOWN | | | | - 12 - | | | SYLVANIA |
| a | 5 | MERIDIAN NURSIN | | } | | | y, town o VERNA | | | ATH | | | E ARU | |
| | 3 | RESIDENCE OF DECEDENT | | | _ | | VEIGIL | 1111 | | | | 71111 | LARO | MDEL |
| DIRECTOR | | MAD STATE 10b. COUNTY | | | 1 | • | OR LOCAT | | | | | | 10 | Id. INSIDE CITY |
| | | MARYLAND ANNE | ARUNDEL | | GT. | EN B | URNI | | | | | | | YES 2 NO |
| FIINERAL | | 116 WELLS AVENUE | R. | | | | 107. | 2106 | | | | | J.S.A. | AT COUNTRY? |
| 1 2 | | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVED IN II C AS | MED | 140 | WAS DES | | | | 17 (Specify Yes | | | |
| | | 1 Never Married 2 Married | | YES 2 X | | | If yes, spe | city Cubar | n, Mexicar | n, Puerto | Rican, etc.) | or No- | | American Indian, White, etc. |
| 2 | - 0 | 3 🕅 Widowed 4 🗌 Divorced | IF TES, GIVE V | WH ON DATES | | | 1 YES | s (XI MO | Specify | r: | | | Specify: | WHITE |
| COMPLETED | | 15. DECEDENT'S EDUC (Specify only highest grade | CATION completed) | (0 | CEDENT'S | work done | during mos | N st of workin | a | 16b | KIND OF BUS | SINESS/IND | USTRY | |
| i i | 1 | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | MEMA | | | | | | OWN HO | ME | | |
| | | 12 17. FATHER'S NAME (First, Middle, Last) | N/A | 110 | TILLIA | KLK | | 40 44071 | 100 to 110 to 11 | | Middle, Maiden | | | |
| E L | | JOHN | FLECH | KER | | | | 18. WOTH | | | ARIE S | | N | |
| g cc |) | 19a. INFORMANT'S NAME (Type/Print) | | | b. MAILING | ADDRES | S (Street a | nd Number | | | ber, City or Tow | | | |
| 2 | - | SUSAN ELLEN MURRA | AY | | | | | | | | VILLE, | | | 21108 |
| | | 20a, METHOD OF DISPOSITION 1 A Burlel 2 Cremation 3 Remains | oval from State | 20b. PLACE cemetery, cre | maton, or o | that along | 4 | | | 84 | 5 | CATION C | | |
| | | 4 Donation 5 Other (Specify) | | - MEADO | WRID | GE M | EMOR. | | | | 4 ELKR | IDGE, | MARY | LAND |
| | | 21. SIGNATURE OF PUBERAL SERVICE LIC | ENSEE | | | S: | INGLE | ETON | FUNE | ERAL | HOME | | | |
| | | 11. I Parge | Stark | in | | | | | | | | | | MD 21061 |
| | | 23. PART I. Enter the diseases, or of shock, or heart failure. | complications the | t caused the de | ath. Do r | not ente | r the mo | de of dyle | ng, suct | aa car | dac or respi | ratory arm | est, | Approximata Interval Between |
| | ł | IMMEDIATE CAUSE (Final | | | | | | / | 1 | | | | | Onset and Death |
| | | disease or condition resulting in death) | MULTE | us Cév | 8320 | V45. | cula | 2 M | CC \$ | 2507 | 5 | | | DAYS |
| | . 1 | | . 1 | (OR AS A CONSE | | • | | | | | | | | V |
| ERTIFICATION | | Sequentially list conditions, if any, leading to immediate | b. // YP | SCTENSI OR AS A CONSE | DUENCE O | 7. | 10 | | | | | | | YEARS |
| IJ. | | cause. Enter UNDERLYING | ATHS | posce: | 52631 | 5 14 | 40 | | | | | | | Year |
| Ē | | CAUSE (Disease or injury that initiated events | | OH AS A CONSE | DUENCE O | F): | | - | | | . 1 | | | 1000 |
| H | | resulting in death) LAST | d. DIA | 32 As 1 | 1864 | 7215 | ALL | 0 / | asse | 000 | 45% | | | Y8425 |
| C | | PART II. Other algolificant condition | a contributing to | death but not | resulting | In the u | nderlying | cause g | lven in i | Part I. | 24a. WAS AN | | | ERE AUTOPSY FINDINGS |
| | | CHRENIC REDIG | c FARLI | 425 | | | | | | | PERFOR | | 00 | MILABLE PRIOR TO OMPLETION OF CAUSE |
| MEDICAL | | | | | | | | | | | | - | 1 | DEATH? |
| | | | | | | | | | | | | | | |
| PHYSICIAN | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHE | | ACE OF DE | EATH (Che | ck only or | 00) | | | |
| X | | 1 YES 2 NO | 1 Inpatient 2 | | | 4 Ru | rsing Home | | sidence | | | | | |
| | | 27. MANNER OF DEATH 1 Netural 5 Pending | 28e. DATE OF (Month, D | | 26b. TIM INJ | E OF IURY M | 28c. INJU | RK? | | 28d. DES | CRIBE HOW I | NJURY OCC | URED | |
| B | - 18 | 2 Accident Investigation | 28e, PLACE O | F INJURY — At he | me ferm | | | ES 2 | NO | 201 1.00 | ATION (Charles | and Mumber | as Orand Orand | - At |
| COMPLETED | | 4 Homicide 6 Could not be determined | building, | etc. (Specify) | | orient, Ide | nory, unite | | | | ATION (Street a or Town, State) | | ur muniti Mout | w rtufficier, |
| Ē | | 29a. CERTIFIER (Check only 1 @ CERTIFYING PHYSIC | CIAN: To the heat of | my knowledne de | off occu- | ad at the | time dat- | and etco: | and do | to the arr | 199(a) a = d = - | | | |
| | | (Check only one) 2 MEDICAL EXAMINE | | | | | | | | | | | | nd manner as stated. |
| E C | | 296. SIGNATURE AND TITLE OF CERTIFIER | | | | | | | NSE NUM | | | 29d. DATE | SIGNED (M | onth, Day, Year) |
| 0 86 | | OZ Z | | | | | | | 999 | | | ▶ 0 | 9-03- | 1994 |
| .1 2 | | 30 NAME AND ADDRESS OF DEDOON WAS | COMPLETED CALL | DE OF DEATH ATE | M 07 (7 | D () | | 4-1 | 666 | | | | | |

DR. DAVID ROSE 200 HOSPITAL DRIVE, GLEN BURNIE, MD

32. REGISTRAR'S SIGNATURE

DR. DAVID ROSE SEP 0 6 1994

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| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | - |
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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the flows after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

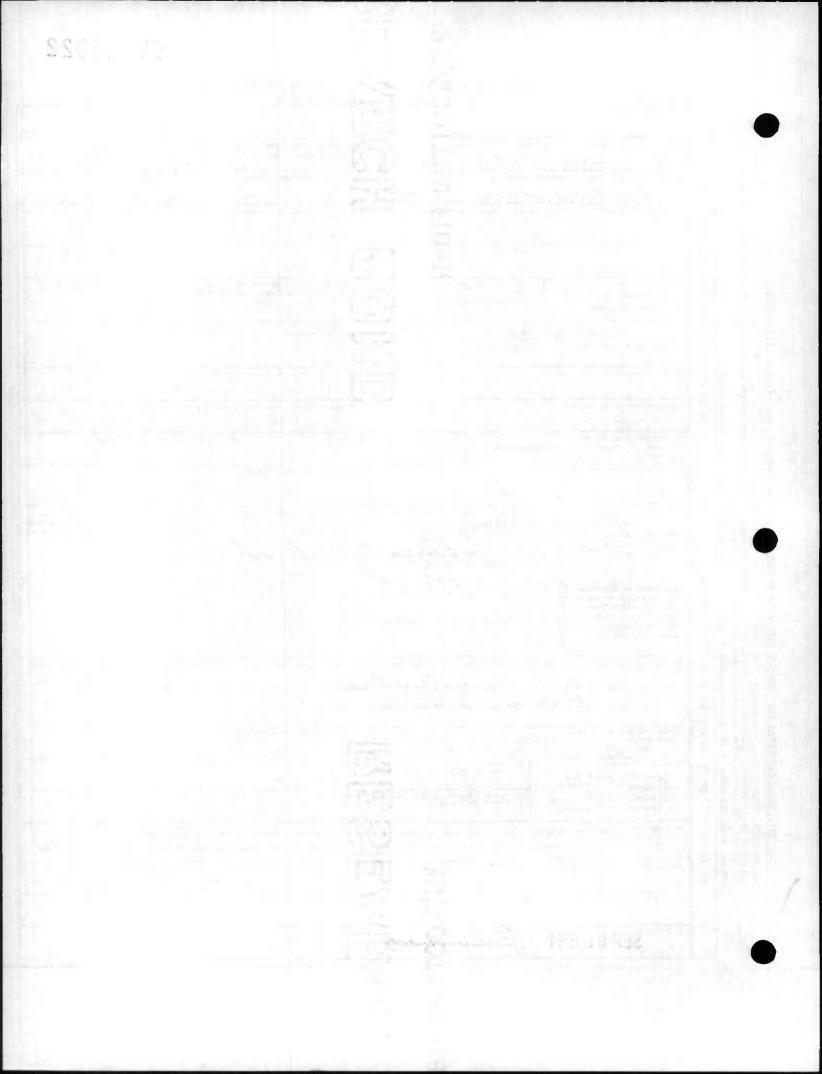
| REGISTRAR | | CERTIFI | CATE OF DEATH | REG. NO |) | |
|--|---|---------------------------|---|-----------------------------|------------------|---|
| 1. DECEDENT'S HAME (First, Middle | FRANCES MAF | RY JENDAUS: | IAK | 2. DATE OF DEATH | AY YEAR | 3. TIME OF DEATH |
| 4. SOCIAL SECURITY HUMBER | 5. SEX 6. AG | E (In yrs. last birthday) | IF UNDER 1 YEAR IF UNDER 24 HR | | 8. B/s | RTHPLACE (State or Foreign |
| 216 01 5210 | 1 [] M 2 [] F | 77 YRS. | MONTHS DAYS HOURS MI | | | untry) |
| 9s. FACILITY HAME (If not institution | abo street and sumbon | | 9b. CITY, TOWN OR LOCATION O | APRIL 3, | 1917 | MARYLAND |
| | - | | 98. CITY, TOWN OR LOCATION O | F DEATH | 9c. COUNTY O | F DEATH |
| MED-BRIDGE N | | | ROSSVILLE | | BALTI | MORE |
| RESIDENCE OF DECEDE | | | | | | |
| 10e. STATE 10b. | COUNTY | 10c. CITY, | TOWN OR LOCATION | | | 10d. INSIDE CITY |
| MD E | ALTIMORE | 809 | SEDALE | | | 1 TES 2 AND |
| 10e. STREET AND HUMBER | | | 101, ZIP CODE | | 10a. CITIZEN O | F WHAT COUNTRY? |
| 7001 51151 | | | 212 | 37 | | USA |
| 7881 OAKDALE | | | | | | |
| 11. MARITAL STATUS | 12. WAS DECEDENT EVER | I IN U.S. ARMED | 13. WAS DECEMBENT OF HIS It yes, specify Cuben, Me | | s or Ho 14, R. | ACE — American Indien, leck, White, atc. |
| 1 Never Merried 2 Merrie | FORCES? 1 YE | DATES | 1 ☐ YES 2 ☑ HO SK | | | pecify: |
| 3/X Widowed 4 Divorced | | | ~ | | | WHITE |
| 15. DECEDENT | 'S EDUCATION | 16a. DECEDENT'S U | SUAL OCCUPATION | 16b. KIHD OF BU | SINESS/INDUSTR | Y |
| (Specify only higher | | (Give kind of we | ork done during most of working retired.) | | | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | | | | |
| 12 | | HOUS | SEWIFE | 1 | HOME | |
| 17. FATHER'S HAME (First, Middle, L | nst) | | 18. MOTHER'S | HAME (First, Middle, Meiden | Surname) | |
| ANOREW J. WI | TISTANT | | MAR | Y FRANCES FI | SCHED | |
| 19a, INFORMANT'S NAME (Type/Pris | | 40h AVAN MIC | | | | |
| The state of the s | * | 1 | ADDRESS (Street and Number or Ru | | | |
| ROSALIE A. GRU | BUMPK I | 7881 | OAKDALE AVE I | ROSEDALE, ME | 21237 | |
| 20a. METHOD OF DISPOSITION | | 0b. PLACE AND DATE OF | FDISPOSITION (Name of | | CATION — City or | |
| 5 Buriel 2 ☐ Cremetion 3 (4 ☐ Donation 6 ☐ Other (Specif | | emetery, crematory or oth | er plece) | 9/9 BAL | TIMORE. | MO |
| 21. SIGNATURE OF JUNERAL SERV | | SACRED HEA | 22. HAME AND ADDRESS OF | | I IMUHE, | MU |
| an order of the service service | 7071 | | | | | |
| (N) C1 | | | LVACH/HOSE | EDALE FUNERA | IL HOME | |
| 23. PART I. Enter the disease | | | 1211 CHES | SACO AVE 213 | 737 | |
| iMMEDIATE CAUSE (Finel disease or condition resulting in death) | a. DUE TO (OR AS | A CONSEQUENCE OF | eilere | | , | Onset end De |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | 0,400 20 |
| | 0 | TO A | 20101 | | | |
| PART II. Other algnificent con | ditione contributing to deeth | but not resulting in | the undarlying ceuse given | in Part I. 24s. WAS AN | | 24b. WERE AUTOPSY FIHDIN |
| | | us | Q 6 -0000 | PERFO | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | 2 /www. | 1 D YES 2 | E (MO | OF DEATH? |
| | Anemic. | A | V | | | 1 _ YES 2 _ NO |
| | /-V | | | | | |
| 25. WAS CASE REFERRED TO MED | CAL | | 26. PLACE OF DEATH | (Check only one) | | |
| EXAMINER? 1 ☐ YES 2 2 € NO | HOSPITAL: | | OTHER: | | | |
| | 1 Inpatient 2 ER/O | | Nursing Home 5 - Residen | ce 6 🗆 Other (Specify) | | |
| 27. MANNER OF DEATH | 28e. DATE OF INJURY (Month, Day, Year | | OF 28c. INJURY AT WORK? | 26d. DESCRIBE HOW | NJURY OCCURED | |
| 1 Accident Investig | 3 | | M 1 YES 2 HO | | | |
| 2 Cutalda | 28e PLACE OF INJUI | RY — At home, farm, at | reet, factory, office | 281. LOCATION (Street | and Number or Du | ral Bouta Number |
| 4 Homicide determ | building, atc. (St | pecify) | | City or Town, State) | | |
| | | | | | 1000 | |
| | PHYSICIAN: To the best of my kno (AMIHER: On the basis of examinat | | | | | se(e) and manner or stated |
| 29b. SIGNATURE AND TITLE OF CE | ATIFIER DUT | 00 | 29c, LICENSE | HUMBER 25593 | 29d. DATE SHOP | ED (Myorin, Day, Year) |
| 30. NAME AND ADDRESS OF PERS | OH WHO COMPLETED CALISE OF I | DEATH (ITEM 27) (Tons | Print) | | 4 | 4-17 |
| MJO | AN COUL | 517A ST | PHMERS R | un ko, | BALT | , MP. |
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| BALTIM | ithik Jours after death. Page |
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| DIVISION OF VITAL RECORDS, P.O. BOX 68/60, | E HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within |
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| | 1. DECEDENT'S NAME (First, Middle, Las | , | V % | | | 2. DATE OF DEAT | | 3. TIME OF DE |
|---|--|---|--|----------------------|--|--|-----------------------------------|--|
| | mary Ann | | | | | 9 | 2 | 14/ 2:1 |
| | 4. SOCIAL SECURITY-WIMBER 188 - 12 - 8994 | 5. SEX 8. A | GE (In yrs. lest birtho | MONTHR | DAYS HOURS MIN. | (Month, Day, Ye | | Country) SCOOL |
| | 9a. FACILITY NAME (If not institution, give | street and number) | | 9b. CITY, | TOWN OR LOCATION OF | | | Y OF DEATH |
| TOR | Crofton Convergence of Decedent | lescent | Center | - (1 | ston, n | UD. | Anc | e Amon |
| DIRECTOR | Maryland Ann | e Arundel | 10c. | GTY, TOWN O | Burnie | | | 10d. INSIDE CI LIMITS? 1 YES 2 |
| | 10e. STREET AND NUMBER | | | 02011 | 10f. ZIP CODE | | 10g. CITIZE | N OF WHAT COUNTRY |
| ER | 211 First Ave. | S.W. | | | 21061 | | Uni | ted States |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVE FORCES? 1 Y | R IN U.S. ARMED | | AS DECENDENT OF HISP | | y Yes or No- 1 | I. RACE — American In Black, White, atc. |
| ВУ | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR O | | | yes, specify Cuban, Max YES 2 X NO Spe | | 3-) | Specify: |
| | | | | | | | | White |
| COMPLETED | 15. DECEDENT'S EL (Specify only highest gra | | 16a. DECEDEN | of work done d | CUPATION luring most of working | 16b. KIND O | F BUSINESS/INDUS | STRY |
| S/E | Elementary/Secondary (0-12) | Coffege (1-4 or 5+) | 27 | | | | Heres | |
| OME | / Yrs. 17. FATHER'S NAME (First, Middle, Last) | | HOME | emaker | 40 4400040 | | Home | |
| | The second second second second | cki | | | | NAME (First, Middle, M | aiden Sumame) | |
| 8E | Stanley Gor | PVT | | 440 (222 | | Casimere | | |
| 9 | CAR MINE TO SERVICE STATE OF THE SERVICE STATE OF T | 1101 | | | (Street and Number or Run | | | |
| | Mrs. Lois J. So. | | | | Ave. S.W. | | | |
| | 20a. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Re | | 20b. PLACE AND DA cemetery, crematory | or other place) | | | c. LOCATION — CI | |
| | 4 Donation 5, Other (Specify) | A CONTRACTOR | Metro | Cremat | | | catonsvi | lle, Maryl |
| | at, signature of therat, service | | | | rkley-Rudd | | al Homo | |
| | Jon Z. C. | bauge | | | 1 Crain Hw | | | nie. MD 21 |
| | 23. PART I. Enter the disesses, o | r complications that cau | sed the death. | o not enter | the mode of dying, a | uch as cardiac or | respiratory arres | it, Approxi |
| | immediate cause (Final | e. List only one cause o | n aach iina. | | | | | intarval Onset a |
| | disease or condition | . / | Linner | int. | An | | | |
| | reaulting in death) | DUE TO (DR | AS A CONSEQUENCE | E OF): | ITAL | | | |
| | | | ASCI | 119 | | | | |
| Z | Sequentially list conditions, | DUE TO (OR A | S A CONSEDUENC | E OF): | | | | |
| | | | | | | | | |
| CATION | if any, leading to immediata cause. Enter UNDERLYING | C | | | | | | |
| FICATION | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | C. DUE TO (OR A | AS A CONSEQUENC | E OF): | | | | |
| ERTIFICATION | if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury | cDUE TO (OR A | AS A CONSEQUENC | E OF): | | | | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | d | | | | 1- D1 1 11 | | |
| - | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | dona contributing to deat | h but not resulti | ng In tha un | | | S AN AUTOPSY RFORMED? | 24b. WERE AUTOPSY AMALABLE PRK |
| - | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | dona contributing to deat | | ng In tha un | | PE | | |
| _ | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | dona contributing to deat | h but not resulti | ng In tha un | | PE | RFORMED? | AWAILABLE PRIC |
| MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | dona contributing to deat | h but not resulti | ng In tha un | | PE | RFORMED? | AWATABLE PRIC COMPLETION O OF DEATH? |
| MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | one contributing to deat | h but not resulti | ng In the und | 26. PLACE OF DEATH (| 1 PE | RFORMED? | AWATABLE PRIC COMPLETION O OF DEATH? |
| MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions to the condition of the condi | dona contributing to deat | h but not resulti | OTHER | 26. PLACE OF DEATH (| PE 1 Vi | RFORMED? ES 2 M-NO | AWATABLE PRIC COMPLETION O OF DEATH? |
| MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions of the condition of the condi | one contributing to deat Verse HOSPITAL: | h but not resulting | OTHER | 26. PLACE OF DEATH (| Check only one) | RFORMED? ES 2 M-NO | AMAILABLE PRIC COMPLETION O OF DEATH? 1 YES 2 |
| PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initisted events resulting in death) LAST PART II. Other significant conditions of the condition of the condi | HOSPITAL: 1 Inpatient 2 ERVI | h but not resulting | OTHER | 26. PLACE OF DEATH (| Check only one) | RFORMED? ES 2 H-NO | AMAILABLE PRIC COMPLETION O OF DEATH? 1 YES 2 |
| D BY PHYSICIAN: MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initisted events resulting in death) LAST PART II. Other significant conditions of the condition of the cause of | HOSPITAL: 1 Inpatient 2 ER/I 28a. DATE OF INJU | Dutpatient 3 Do | OTHER 4 OTHER NURY M | 26. PLACE OF DEATH (1: Ing Home 5 GRealdence 28c. INJURY AT WORK? 1 YES 2 ND | Check only one) 28d. DESCRIBE H 28f. LOCATION (S | RFORMED? ES 2 -NO OW INJURY OCCU | AMAILABLE PRIC COMPLETION O OF DEATH? 1 YES 2 |
| ED BY PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initisted events resulting in dasth) LAST PART II. Other significant conditions of the condition of the condi | HOSPITAL: 1 Inpatient 2 ERVI (Month, Day, Yes | Dutpatient 3 Do | OTHER 4 OTHER NURY M | 26. PLACE OF DEATH (1: Ing Home 5 GRealdence 28c. INJURY AT WORK? 1 YES 2 ND | **Check only one) to 6 Other (Specify 28d. DESCRIBE H | RFORMED? ES 2 -NO OW INJURY OCCU | AMALABLE PRIC COMPLETION O OF DEATH? 1 YES 2 RED |
| COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initisted events resulting in death) LAST PART II. Other significant conditions of the condition of the condi | HOSPITAL: 1 Inpatient 2 ERVI (Month, Day, Yes | Dutpatient 3 Do | OTHER 4V Nurs | 26. PLACE OF DEATH (I: lng Home 5 Residence 28c. INJURY AT WORK? 1 YES 2 ND ory, office | Check only one) 28d. DESCRIBE I 28f. LOCATION (S City or Town, | RFORMED? ES 2 NO OW INJURY OCCU | AMALABLE PRIC COMPLETION O OF DEATH? 1 YES 2 RED RED |

1655 Crofton Blvd. Crofton, MD



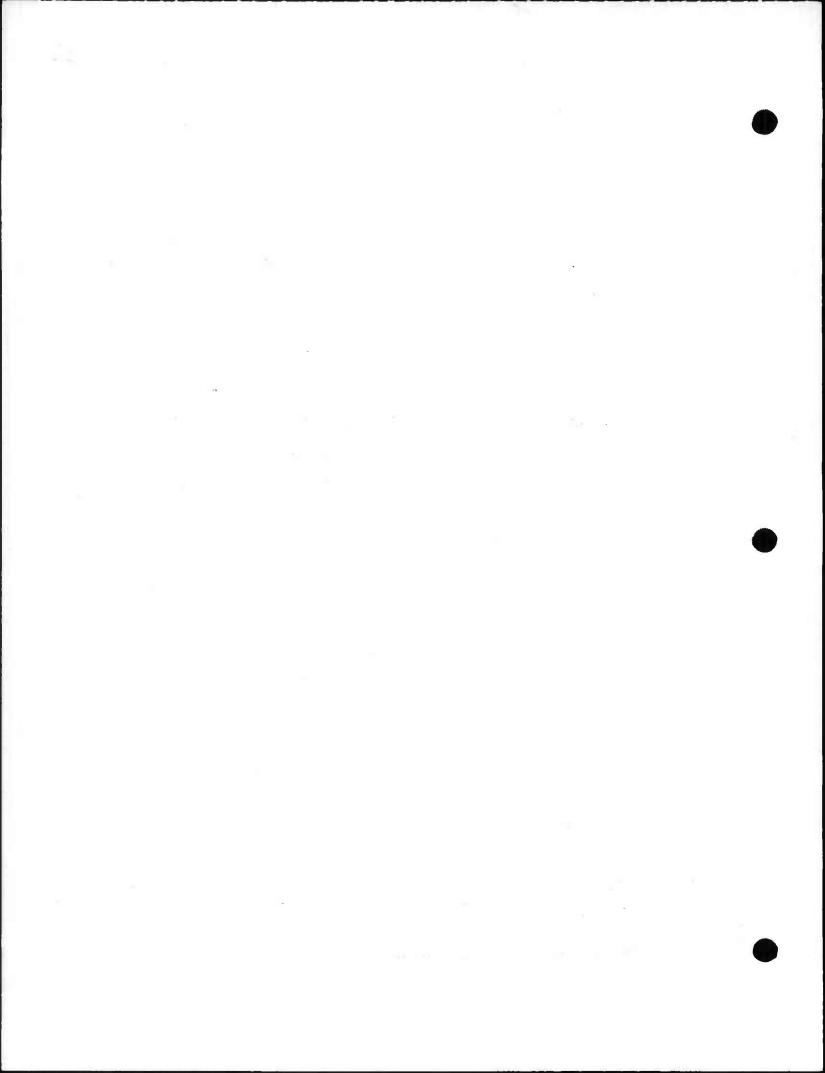
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | | 1. DECEDENT'S NAME (First, Middle, Last) | Lawrence | W. Jone | 25 | | 2. DATE OF DEATH | 1994 | 3. TIME OF DEATH | | |
|--|---------------|---|---|---|----------------------------------|--|---|-------------------------------------|--|--|--|
| | | 4. SOCIAL SECURITY NUMBER 224-42-4780 | | (In yrs. last birthday) 59 YRS. | IF UNDER 1 YE | | 7. DATE OF BIRTH (Month, Day, Year) 8-10-1 | 8. BIRT | HPLACE (State or Foreign Ty) V a | | |
| 2, 3 should | стов | 9a. FACILITY NAME (If not institution, give she Bayview Hospit RESIDENCE OF DECEDENT | _ | | 96. СІТУ, ТОУ Ва11 | VN OR LOCATION OF | DEATH 9c. COUNTY OF DEATH | | | | |
| permit, Pages 1, | DIREC | 10a. STATE 10b. COUNTY | | | y, town or Lo | DCATION | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | |
| TS. | ERAL | 100. STREET AND NUMBER 5803 Waycross | Road | | | 101. ZIP CODE 21206 | 10g. CITIZEN OF WHAT COUNTRY? | | | | |
| 215-0020 Intending physician. Se as the burial-transit | BY FUNER | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Olvorced | 12. WAS OECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR | 2 NO | If yes | OECENOENT OF HISP , specify Cuban, Maxi YES 2 NO Spe | F HISPANIC ORIGIN? (Specify Yea or No— 14. RACE — American Indian, Black, White, atc. Specify: Black | | | | |
| 12 mg | LETED | 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) | | life. Do NOT u | work done during se retired.) | most of working | | SINESS/INDUSTRY | omo anu | | |
| YLAND by the hospital be detached to all once. | 0 | 12th 17. FATHER'S NAME (First, Middle, Lest) William Jones | | Product | Ton Su | 18. MOTHER'S | IAME (First, Middle, Maiden am Thompson | | orpany | | |
| be retained ge 5 should e notifiled | | 19a. INFORMANT'S NAME (Type/Print) Emma V. Jones | | | | | I Route Number, City or Tow | vn, State, Zip Code) | | | |
| TIMORE, Page 6 may be rat director, page inter must be | | 20a. METHOD OF DISPOSITION 11 Burlet 2 Cremation 3 Ramo 4 Donation 5 Other (Specify) | val from State C6 | b. PLACE AND DATE | of disposition Memor i | al Park | | butus, Mo | · · | | |
| SAL robert w tyne | | 21. SIGNATURE OF FUNERAL SERVICE LICE | Ma | leh. | | eand address of arch F/H 300 Waba | West sh Avenue | Balto. M | d 21215 | | |
| SIGNATE The IMPROPERTY OF CO. BOX 504700. SIGNATE The IMPROPERTY OF CO. BOX 504700. CONTINUES HAVE BEEN SERVED BY THE ABEND OF PRICE OF CONDITION FIRST OF THE SERVED BY THE CHEMISTON OF THE CHEMIST OF THE CHEMIST OF THE CHEMISTRE AND A | SICIAN: MEDIC | 23. PART . Entar the diseases, or conshock, or heart feliura. L. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRIED TO MEDICAL EXAMINER? 1 YES NO | DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS | A CONSEQUENCE O A CONSEQUENCE O A CONSEQUENCE O Dut not resulting OF DEATH YE 28. PLACE OF DEA | in the under | ying cause given i | n Part I. 24a. WAS AN PERFOI | I AUTOPSY 24R | Approximate interval Between Onset and Death | | |
| NG PHYSICIA her this certification with the marked, or | ву РНУ | 27. MANNER OF DEATH 1. Return 5 Pending 2 Accident Investigation | 28a. DAYE OF INJURY (Month, Day, Year) | | E OF 28c. | INJURY AT WORK? YES 2 NO | 28d. DESCRIBE HOW | INJURY OCCURED | | | |
| CTURNO CTUR A CTUR A STATE S | ETED B | 3 Suicide 6 Could not be 4 Momicide determined | 28a. PLACE OF INJUR building, atc. (Spo | Y — At home, farm, ecify) | rtreet, factory, (| offica | 28f. LOCATION (Street City or Town, State) | and Number or Rural :) | Route Number, | | |
| Z Z Z = | APL | MEDICAL EXAMINER | IAN: To the beat of my know: On the beals of exeminati | | | | | | a) and manner as atated. | | |
| TO THE HOSPIT TO THE FUNER De fied within IMPORTANT. | TO BE | 29b. SIGNATURE AND PITTLE OF CERTIFIER 30. NAME AND HIDDRESS OF PERSON WISO | COUNTY DI CAUSE OF B | EATH (ITEM 27) (See | Delast | 29c LICENSE N | 5814 | 29d, DATE SIGNED | (Month. Gay, Year) | | |
| 10 | | 1505 C | 32. REGISTRAR'S SIG | PRIVE | 5 | UNTE : | 5041 | O WSON | ain, | | |
| \bullet^{ψ} | | SEP 0 6 1994 | Just Sin | | | | | | DHMH 46 Bay 460 | | |





FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

| _ | | | - 00 | | IOAIC | . 01 | DEAL | | nc | G. NO. | | | |
|---------------|--|---------------------------------------|---------------------------------------|--------------|----------------|----------------|----------------------|--------------|--------------------------------|-----------|-----------------|--------------------|---|
| | DECEDENT'S NAME (First, Middle, Last) | Clude | Malachia | r Kno | itts | | | | 2. DATE OF DE | DA | | YEAR | 3. TIME OF DEATH |
| | | | | | | | | | Septem | | 1, | 1994 | M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. lest | | IF UNDER | t YEAR DAYS | HOURS | 24 HRS. | 7. DATE OF BII (Month, Day, | Year) | | 8. BIRTH Countr | IPLACE (Stete or Foreign y) |
| | 232-58-6341 | | 58 | YRS. | | | | | 02/14 | /19. | | | st Virginia |
| œ | 99. FACILITY NAME (If not institution, give st | | | | 9b. CITY, | | R LOCATIO | ON OF DEA | ATH | | | JNTY OF D | |
| DIRECTOR | 2020 Ewald Avenu | le | | | | vun | dalk | | | | | Balt | imore |
| <u> </u> | 10a. STATE 10b. COUNTY | | | 10c. CIT | Y, TOWN O | R LOCAT | ION | | | | | | 10d. INSIDE CITY |
| E | Maryland | Baltin | nore | | | | | Dun | dalk | | | | LIMITS? 1 YES 2 NO |
| | 10e. STREET AND NUMBER | | | | | 101 | . ZIP CODE | | | | 10g. CI1 | TIZEN OF V | WHAT COUNTRY? |
| FUNERAL | 2020 Ewald Avenu | Le. | | | | | | 21 | 222 | | | lluit | ed States |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. ARI | MED | | | | F HISPANI | C ORIGIN? (Spe | | | | — American Indian, |
| BY F | 1 Never Merried 2 Merried 3 Wildowed 4 C Divorced | IF YES, GIVE V | WAR OR DATES | 0 | | | ecify Cuben 2)(NO | | , Puerlo Ricen, | etc.) | | Speci | tv: |
| | | | Conflic | <u>t</u> | | | | | | | | <u> </u> | White |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | | (G/ | ve kind of v | USUAL OC | | ON st of working | g | 16b, KIND | OF BUS | INESS/IN | DUSTRY | |
| | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | Do NOT us | | | | | | | | | |
| MP | 11th Grade | | 1 1 | Mach | ine o | peru | ator | | | | | Wire | Company |
| | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | | E (First, Middle, | | | | |
| BE | Clarence Knotts 190. INFORMANT'S NAME (Typos/Print) | _ | - I | | | | | | . V. Wi | | | | |
| 임 | The second secon | 244 | 190 | | | | | | Oute Number, City | | | | 01.000 |
| | Lorretto J. Lipy |) <u> </u> | 20b. PLACE A | | | | | iue_ | Dundal | _ | | | |
| | 1 Suriel 2 X Cremetion 3 Remo | val from State | cemetery crer | netory or o | ther place) | ITION (Na | Catus | 0/2 | DATE | 20c. LO | ATION - | City or To | wn, State |
| i | 21. SIGNATURE OF SUNERAL SERVICE LIC | ENSEE (| Tinge | cop. | 22.1 | NAME AN | ID ADDRES | S OF FAC | LITY | | | | |
| | 1/2 / M/ | 7 | 1 | | Du | ida- | Ruck | Fune | ral Ho | me 1 | 06 D | undal | ck, Inc. |
| _ | - Crun 111 | · Kn | y | | 79 | 122 | Wise | Ave. | Dund | alk | , MD | 21: | 222 |
| | 23. PART I. Entar tha diseases, or c shock, or haart fallure. I | omplications the list only one cau | t caysed the dea use on aach ilna. | ath. Dor | not antar | tha mo | de ot dyir | ng, auch | as cardiac o | r reapi | atory a | rreat, | Approximata interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | P | | , | 00 | .0 | | | .0 |) | 0 | 0 | Onset and Death |
| | reaulting in death) | ding | Cenist, | Sm | er o | U, | Coral | n pro | Wh | 1 | leps | 1/2/20 | |
| | | 54410 | (OH AS A CONSEC | DENCE OF | F): | | | | | | . (| | |
| CERTIFICATION | Sequentially list conditions, | DUE TO | (OR AS A CONSEC | UENCE O | n: | | | | | | | | |
| Ä | If any, laading to immadiata cause. Entar UNDERLYING | | | | | | | | | | | | j |
| Ĕ | CAUSE (Disease or injury that initiated avents | DUE TO | (OR AS A CONSEC | UENCE OF | F): | | | | | | | | |
| | resulting in death) LAST | | | | | | | | | | | | |
| | PART II. Other algorificant conditions | . contribution to | diest bus | - 101 - 1 | | | | | | - | | | |
| EDICAL | Chroni Obstrict | 0. | // | - | in the un | dariying | g causa gi | Ivan In P | art 1. 24a, 1 | PERFORI | AUTOPSY MED? | 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| ă | CANONE OBSTUCIO | " Jun | may L | 26- | | | | | _ 1 🗆 | YES 2 | □ NO | | COMPLETION OF CAUSE OF DEATH? |
| Σ | DID TODA CCO LICE COLUM | | | | | | | | | | | | 1 YES 2 NO |
| PHYSICIAN: | DID TOBACCO USE CONTR | IBUTE TO CA | | _ | | | UNC | ERTAIN | | | | | |
| S | EXAMINER? | HOSPITAL: | | | OTHER | 1: | 16 | JULIE - 11.0 | | | | | |
| ¥ | 27. MANNER OF DEATH | 28e. DATE OF | ER/Outpatient 3 | 28b. TIM | 4 Nurs | Ing Home | - | | Other (Spec | | IIII OC | CUBEO | |
| | 1 Natural 5 Pending | (Month, D | | INJ | URY M | WO | | | LOG. DEGOTIBE | | ooni oc | CONED | |
| BY | 2 Accident Investigation 3 Suicide & Could not be | 28e. PLACE D | F INJURY — At hor | ne, ferm, a | treet, facto | | | - | 28f. LOCATION | (Street e | nd Numbe | or Rural R | loute Number |
| | 6 Could not be 4 Homicide determined | building, | etc. (Specify) | | | | | | City or Town | n, Stete) | | | and trained, |
| | 29e. CERTIFIER (Check only | IAN: To the best of | mu knowledge des | th accum | of set the sta | 4-4- | adarates: | | | | | | |
| COMPLETE | | | | | | | | | | | | |) and menner as stated, |
| - 11 | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | , my op | 1 | | | | | | | |
| 닒 | 290. SIGNATURE AND TITLE OF CERTIFIER | ch. | | | | | 29c. LICEN | 101 1000 | | | 29d, DAT | E SIGNED | (Month, Day, Year) |
| ၉ | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CALL | SE OF DEATH STEM | 27) /* | Drigo) | | 0- | 181. | 5-1 | | 7 | -2-1 | 4 |
| | | | | | | 4 | . n | . 7 | MD | 27.0 | 23 | | , |
| | Chi-Shiang Chen, | QV32. REGISTA | A. IUU | IY. | proa(| ıwa y | RS | dito | , MD | 212 | 31 | | |
| | 31. DATE FILED (Month SEV. Part) 6 19 | سل اا | and distribution | - Naco | - | | | | | | | | |

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with completely filled in by the funeral director, page 5 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notitied at once. DIVISION OF VITAL RECORDS, P.O. BOX 687604

BALTIMORE, MARYLAND 21215-0020

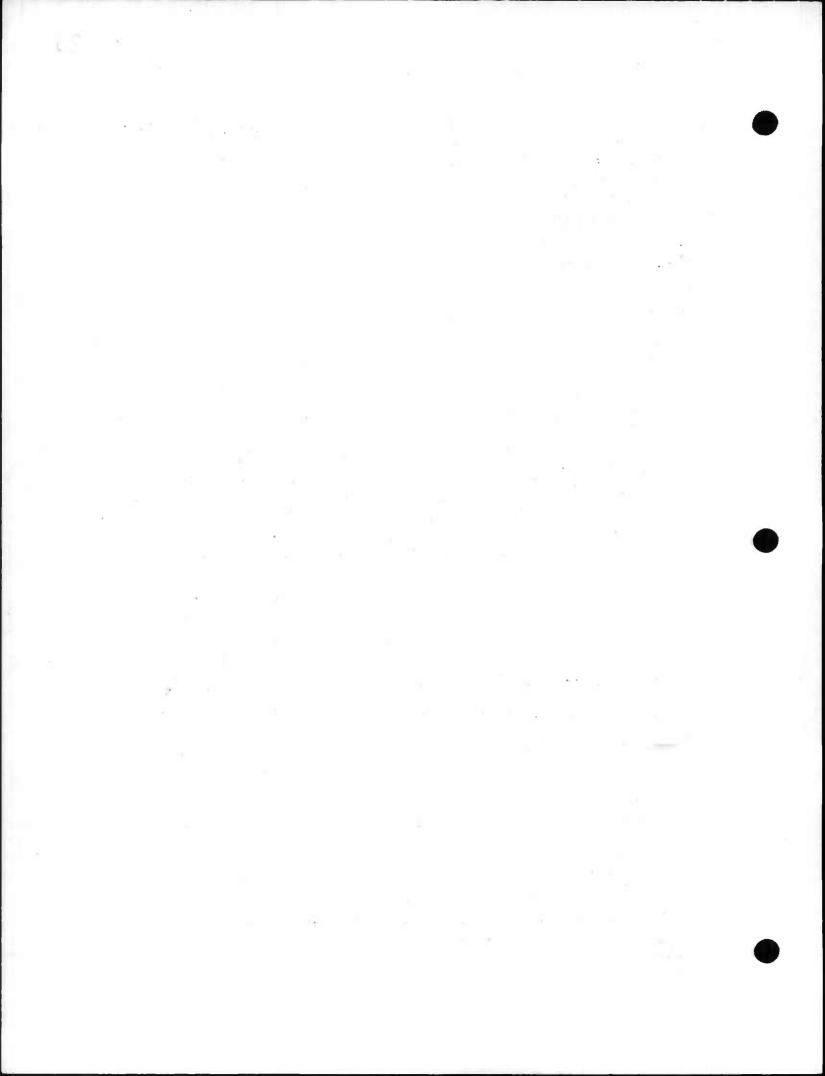
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DIVISION OF VITAL BECORDS P.O.

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| | | REGISTRAR | | | CERTIF | ICATE | OF | DEA | ГН | | REG. NO. | | | |
|--|-------------|--|------------------------------|-----------------|-------------------------------|-----------------------------|---------|-----------------|----------|-------------------------------|----------------------|-------------|----------------------|-----------------------------------|
| | | 1. DECEDENT'S NAME (First, Middle, Las STEVE MOTSKO | 0 | | | | | | | 2. DATE O MONTH | DA | NY | VEAD | 3. TIME OF DEATN |
| | | | | | | | | _ | _ | SEPTE | 1 17 17 | 2, 19 | 994 | 11:05 a. м |
| | | 4. SOCIAL SECURITY NUMBER | 5. \$EX | 6. AGE (In yrs. | last birthday) | IF UNDER | DAYS | HOURS | MIN. | | Day, Year) | | Country) | |
| pinc | | 190-03-2951 9e. FACILITY NAME (If not institution, give | | 78 | Tho. | AL CITY | TOMAL | 0010017 | | Decemb | er 27, | | Erne | |
| 3 should | œ | VA MEDICAL CENT | | | | | | OR LOCATI | | EATH | | | TY OF DE | |
| 1, 2, | DIRECTOR | RESIDENCE OF DECEDENT | EIK | | | FOR | CT. I | HOWAR | D | | | BAL | TIMOR | E |
| Sege | RE | 10a. STATE 10b. COUR | ITY | | | Y, TOWN O | | TION | | | | | | 10d. INSIDE CITY |
| it. P | 1 1 | Maryland | | | _ Ba. | ltimo | re | | | | | | | YES 2 NO |
| r per | 3AL | 10e. STREET AND NUMBER | | | | | 10 | M. ZIP COD | | | | | | HAT COUNTRY? |
| physician. burial-transit permit. Pages 1, | FUNERAL | 6120 Rusk Avenu | | | | | | 2120 | | <u> </u> | | | S.A. | |
| ig physici | | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDEN FORCES? 1 | YES 2 | ARMED NO | 11 | yes, s | pecify Cuba | | NIC ORIGIN? In, Puerlo Ric | | or No- | 14. RACE - Black, | - American Indian, White, atc. |
| ing p | BY | 3 📉 Widowed 4 🗌 Divorced | WW.T.T | AR OR DATES | | 1 | ☐ YES | S 2X NO | Specify | y: | | | Specify | white |
| r attending physician use as the burial-fra | ED | 15. DECEDENT'S Et (Specify only highest gra | DUCATION | 18a. | DECEOENT'S | USUAL OC | CUPATI | ION | | 18b. F | IND OF BUS | SINESS/IND | USTRY | WILLCE |
| or all or us | COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | (Give kind of life, Do NOT us | work done d se retired.) | uring m | lost of workli | 1g | | | | | |
| the hospital or detached for u | MP | 8 years | | Ca | irpenter | / Hom | e Bu | ilder | | Co | nstru | ction | 1 | |
| | 8 | 17. FATNER'S NAME (First, Middle, Last) Elias Motsko | | | | | | | | ME (First, Mic | | Surname) | | |
| ed by ed at | BE | | | | | | | | | chalo | | | | |
| retained 5 should notified | 2 | John Motsko (bro | other) | | 196. MAILING | | | | | Balti | | | | |
| be d | | 20 METNOD OF DISPOSITION | Jener / | 205 01 4 | CE AND DATE | _ | | | uc, | | | CATION — | | |
| ter death. Page 6 may be the funeral director, page yal. | | 1 	☐ Buriel 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) | moval from State | cemetery. | Ridge C | ther place) | TION(N | onton | m 6 | 1 OO/ | Dilma | ville, | | |
| Page al direc | | 21. SIGNATUBE OF TUNERAL SERVICE | | O | Muse C | 22. N | NAME A | ND ADDRE | SS OF FA | CILITY | | | | and |
| death. Pag tuneral di f. | | Thomas Jose | | 2 | | | | | | efeld | | | | |
| by the emoval. | \vdash | 23. PART I. Enter the diseases, o | _ | t caused the | death Do | 65 | 00 | York | Rd. | Balt | imore | , MD | 2121 | |
| (0 0) 93 | | shock, or heart fellure | . List only one cau | ise on each I | line. | iot enter | tire in | oue or dy | ing, auc | ii aa ceruii | c or reap | ratory arn | est, | Approximata interval Between |
| y filler fron, | | iMMEDIATE CAUSE (Finel disease or condition | | | | | | | | | | | | Onset and Death |
| tted within course completely filled in ial. cremation, or re- | 1 1 | resulting in death) | a. RECURE | OR AS A CON | REBROY | ZASCU F): | LAR | ACC: | IDEN' | Г | | | | |
| ecuted ind com burial, | z | | | | | | | | | | | | | İ |
| 3 ° 0 F | RTIFICATION | Sequentially list conditions, if any, leeding to immediate | OUE TO | (OR AS A CON | SEQUENCE O | F): | | | | | | | - | |
| ficate be physician ne prior t | 2 | cause. Enter UNDERLYING CAUSE (Disease or injury | c | | | | | | _ | | | | | |
| nding ph Hygiene | E | that initiated events reaulting in desth) LAST | DUE TO | (OR AS A CON | SECUENCE O | F): | | | | | | | | |
| = = = = | 1 00 1 | | d | - | - | | | | | | | | | + |
| 를 등을 을 | | PART ii. Other algnificent conditi | | | | | derlyin | ng ceuse | given in | Part I. | 4a. WAS AN PERFOR | | | WERE AUTOPSY FINDINGS |
| that the | 8 | CHRONIC OBSTRUCT | TIVE PULMO | NARY D | ISEASI | 3 | | | | _ | TENTON | | (| COMPLETION OF CAUSE OF DEATH? |
| requires been sign of Healt | ME | | | | | | | | | | | V | | 1 YES 2 NO |
| law re as been bept. | AN: | DID TOBACCO USE | CONTRIBUTE | TO CA | USE OF | DEAT | H) | YES | NC. | | | | | |
| YSICIAN: The faw requisions certificate has been so the State Dept. of H id, or Item 23 show | SICI | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER | | LACE OF D | EATN (Ch | eck only one) | | | | |
| CLAN: ertific the S | HYS | 27. MANNER OF DEATH | HOSPITAL: | | | 4 🗆 Nurs | Ing Hon | | sidenca | 8 🗆 Other (| | | | |
| NG PHYS frer this c eath with | 0 | 1X Netural 5 Pending | 28a. DATE OF (Month, D | | 28b. TIM | URY M | W | JURY AT ORK? | 7.00 | 28d. DEŞC | RIBE NOW II | NJURY OCC | URED | |
| After After death | ВУ | 2 Accident Investigation 3 Suicide 8 Could not be | 28a, PLACE O | F INJURY — AI | home, farm | street, facto | | YES 2 |] NO | 28f LOCAT | ION (Street a | and Alumbas | or Primi Bo | rds Mumber |
| | TED | 4 Nomicide 8 Could not b | • building, | etc. (Specify) | | | ,, | | | City or | Town, State) | ING THUMBON | or ribrar rior | ne mambel, |
| OR ATTEN DIRECTOR hours after Item 28 | I W I | 29a. CERTIFIER 1 CERTIFYING PN | SICIAN: To the best of | my knowledge | death assum | ad at the tie | a det | and state | | An Abraham | | | | - |
| 7 72 - | COMPL | (Check only one) 2 MEOICAL EXAMI | | | | | | | | | | | | end menner as stated. |
| FUN WITH | E C | 296. SIGNATURE AND TITLE OF CERTIF | | | | | _ | 1 | ENSE NUR | | | | | Month, Day, Year) |
| TO THE HOSPITA TO THE FUNERA De filed within 7 IMPORTANT: 1 | 8 | -terthus, | 1 | | | | | 0101 | | | VA | | 9/2/9 | |
| | 임 | TO NAME AND ADDRESS OF PERSON V | VNO COMPLETED CAUS | SE OF DEATH (| ITEM 27) (Type | , Print) | | 10.00 | /- | | | • | ,, 4,) | - |
| | | CHERUKOPH C.J. V | ERGHESE, | M.D., | VA MET | ICAL | CE | NTER. | FOR | RT HOW | VARD. | MD 2 | 1052 | |
| | | 31. DATE FREE MOTE 6 1994 | A 22. REGISTRA | T'S SIGNATUR | E . | | | | | | | | | |
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DIVISION OF VITAL RECOR

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91, 26026 Item5 9-6-94 FilmG715 W.H.Per F/H 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) Catherine M. Miller 2. DATE OF DEATH 3. TIME OF DEATH THER 9 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DAYS 1-M 2 F 13-10-6020 110 BA 9a. FACILITY NAME (If not institution, give street and number) HAMILTON 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR MERIDIAN NURSING enter-BALTIMORE 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Baltimore 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 6040 Harford Road 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6040 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married 1 YES 2 NO Specify: WHITE В Specify 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Stewart's Dept. Store Saleslady 6th Grade 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Matthew We1ch Emma Neuman ш B 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 103 Kennard Avenue Edgewood, Maryland-21040 Sharon M. Miller 20a_METHOD OF DISPOSITION
1 Burlal 2 Cremation 3 Removal from State 206. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State Mount Carmel Cemetery 9-6 Baltimore, Maryland 4 Donalion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 6415 BElair Road Baltimore, Md. -21206 John C. Miller, Inc. 23. PART i. Enter the diseases, or complicatione that caused the death. Do not enter the mode of dying, such as cardiec or respiratory street, shock, or heert fellure. Liet only one cause on each line interval Retween IMMEDIATE CAUSE (Final Onset and Death disease or condition DUE TO (OR AS A CONSEQUENCE OF): resulting in desth) Chronic Chronic Aspiratus
DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentisity ilst conditions, if sny, leading to immediate Sange Hicken.

DUE TO OR AS A CONSEQUENCE OF: Heinia with Gastro-esophiged Reflex cause. Enter UNDERLYING CAUSE (Disesse or injury thet initieted events resulting in desth) LAST PART ii. Other eignificent conditione contributing to death but not recuiting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 TES 2 NO 1 | YES 2 | NO PHYSICIAN:

25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) FXAMINER? HOSPITAL: OTHER: 1 YES 2 NO 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY 26b. TIME OF 26c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO 2 Accident Investigation 26a. PLACE OF INJURY — At homa, farm, street, factory, offica building, etc. (Specify) 3 Suicide 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide

29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Sept. 3 currenter mark! 10 016619

30. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

06 1994

determined

O. VERBARA. SOARES N. BROADWAY ST. 100 BALT. M.D. 21231

32. REGISTRARY SIGNATURE

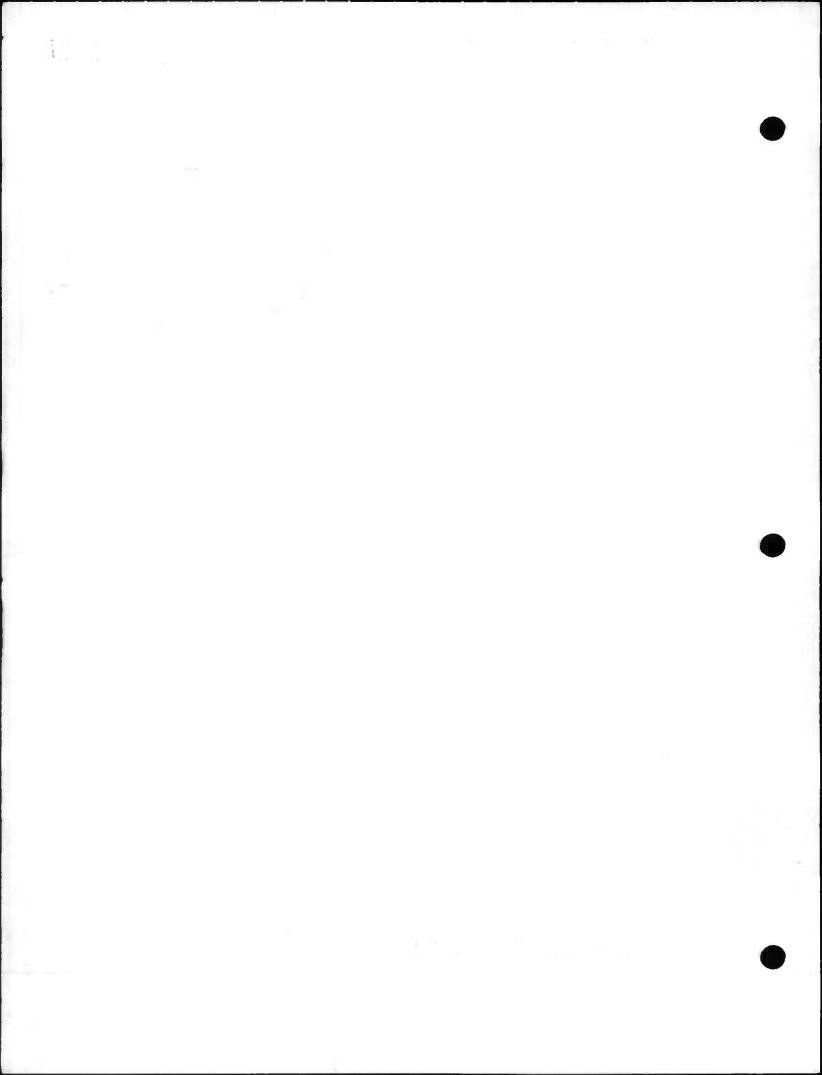
94 Julia Dawalson Randall

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STATE REGISTRAR CERTIFICATE OF DEATH DECEDENT'S NAME (First, Middle 2. DATE OF DEATH 3. TIME OF DEATH CTEER MONTH 9 YEAR 94 5. SEX B. AGE (In yrs. lest birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 43 1175794 RICHMOND VA. XXM 2 F use as the burial-transit permit. Pages 1, 2, 3 should ition, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR BALTIMORE CITY CHURCH HOSPITAL RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD BALTIMORE CITY XX YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2004 E. PRESTON ST 21213 USA 24 hours after death. Page 6 may be retained by the hospital or attending physician. filled in by the funeral director, page 5 should be detached for use as the burlat-tran 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES X NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) RACE — American Indian, Black, White, etc. 1 Never Married >2 Married ВҰ 1 YES ZONO Specify Specify: BLACK 3 Widowed 4 Divorced COMPLETED 18e. DECEDENT'S USUAL OCCUPATION
(Glue kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp MAIL HANDLER US. POSTAL SERVICE Elementary/Secondary (0-12) College (1-4 or 5+) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) STEWART MCTEER FANNIE WALKER notified at BE City or Town, State, Zip Code) MD. 21213 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, 9 M^Cteer ANTOINETTE 2004 E. PRESTON ST. BALTO MD. pe 20s. METHOD OF DISPOSITION

School 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must BALTIMORE CEMETERY BALTIMORE CITY 9/7 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner led in by the funeral d 22. NAME AND ADDRESS OF FACILITY 12 - Locker LOCKS FUNERAL HOME/1304 N. CENTRAL AVI medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, completely filled in by ial, cremation, or remo Approximata shock, or heart fellure. List only one cause on each line interval Between **IMMEDIATE CAUSE (Final Onset and Death** grestensive Arteroscleratio Carlo Vascula Disso traumatic event, the disease or condition resulting in death) ION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEQUENCE OF) and com o burial, CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING physician DING PHYSICIAN: The law requires that the death certificate be CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events signed by the attending Health and Mental Hygiei resulting in death) LAST 6 shows any injury, PART II. Other algniticant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO s certificate has been si th the State Dept. of Ho id, or item 23 show 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA ne 5 🗆 Residence 6 🗆 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) with t 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED is marked, 1 Netural
2 Accident 1 YES 2 NO After th BY 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 28 4 Homicide Item 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE FLANCEL D
TO THE FLANCEL D
TO Seed within 72. MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, deta and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29d. DATE SIGNED (Month, Day, Year) colento YOU MID 60 9-1-94 9 IRSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print Church Jalia d'Audior La SEP 06 1994



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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death, Page 6 may be retained by the hospital or attending physician.

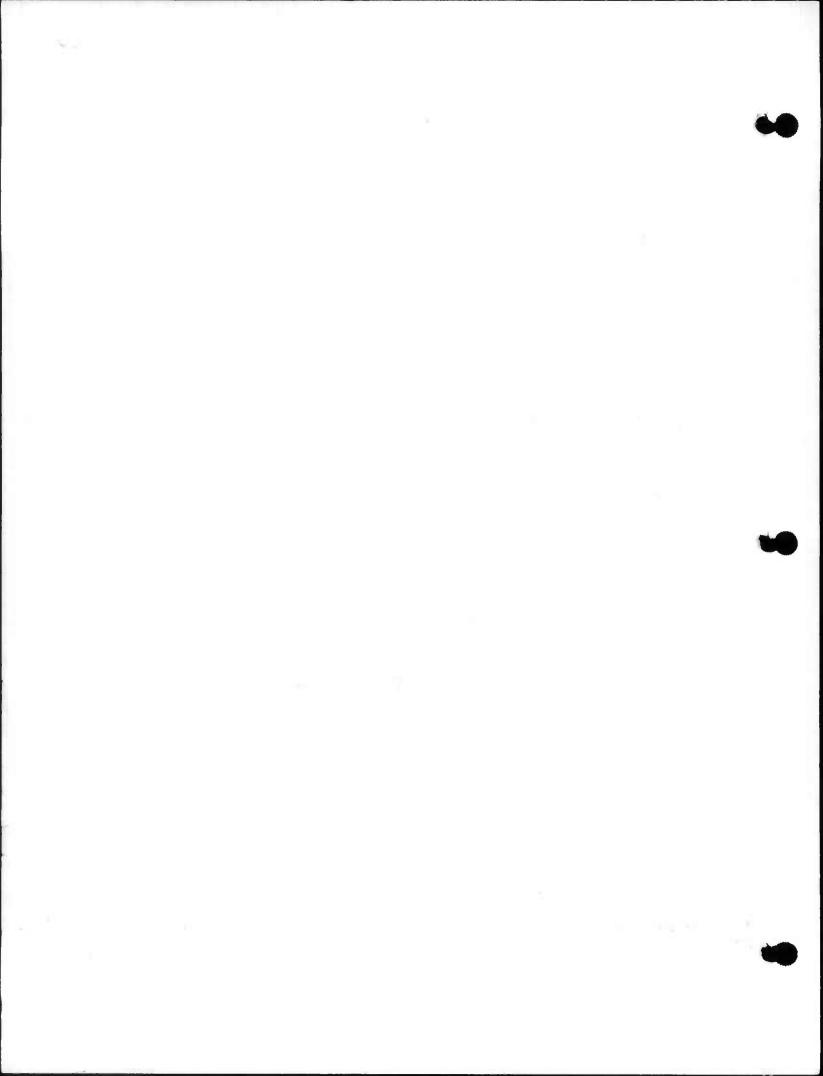
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should

| | FOR 1 - STATE REGISTRAR | | STATE OF I | MARYLAND | / DEPAR | RTMENT | OF H | EALTH AND DEATH | MENTA | L HYGIEN | | | |
|--------------------------------------|--|--|------------------------|-----------------|---------------------------------|---------------|------------|--|--------------|---------------------------------------|---------------|--------------|--|
| | t. DECEDENT'S NAME (First, | Middle, Last) | | | | TOATE | 0. | DEATH | | OF DEATH | | 3 | . TIME OF DEATH |
| | Helen M. | McC1 | oskey | | | | | | Sept | ember 1 | ı. 1994 | YEAR | 8:40 P. M |
| | 4. SOCIAL SECURITY NUMBER | ER | 5. SEX | 6. AGE (In yrs. | lest birthday) | IF UNDER | | IF UNDER 24 HRS. | 7. DATE | OF BIRTH | | _ | ACE (State or Foreign |
| | 215-01-4925 | | 1 🗆 M 2 😿 F | 96 | YRS. | MONTHS | DAYS | HOURS MIN. | | 17,18 | 397 | Maryl | and |
| | 9a. FACILITY NAME (If not ins | | | | | 9b. CITY, | TOWN C | OR LOCATION OF D | | | | TY OF DEA | тн |
| 1 6 | Meridian Lor | ng Gre | en Nursi | ng Home | e | Bal | imc | ore City | | | | | |
| DIRECTO | 10a. STATE | tob. COUNTY | , | | 10c. CI1 | Y, TOWN O | LOCAT | ION | | | | 10 | Dd. INSIDE CITY |
| l le | Maryland | | | | Bal | timo | e (| lity | | | | t | LIMITS? |
| A P | | | | | | | _ | ZIP CODE | | | 10g. CITIZ | | AT COUNTRY? |
| FUNERAL | 115 E. Melro | ose Av | enue | | | | 2 | 21212 | | | | U.S | .A. |
| Ę | 11. MARITAL STATUS 1 X Never Married 2 1 | | 12. WAS DECEDER | T EVER IN U.S. | ARMED K NO | 13. V | AS DEC | ENDENT OF HISPA | NIC ORIGI | N? (Specify Yes | or No- | 14. RACE | - American Indian, White, atc. |
| B≼ | 3 Widowed 4 Divor | | IF YES, GIVE | | | t | ☐ YES | 2 NO Speci | | , , , , , , , , , , , , , , , , , , , | | Specify | |
| | 15. DECE | EDENT'S EDUC | CATION | 18.0 | DECEDENT'S | I I OC | CLIDATIC | N . | 1 444 | , KIND OF BUS | DINESS (INDI | | White |
| once. | | highest grade | | | (Give kind of life. Do NOT u | work done d | ring mo | st of working | 100 | . KIND OF BU | SINE 35/IND | JSTRY | |
| 1 | Lienski y occordiny (o | , | College (1-4 of 5 | ′ | Billir | ng Cle | erk | | 1 | rintir | ne Pre | 222 | |
| S S | 17. FATHER'S NAME (First, Mid | ddle, Last) | | | | | | 18. MOTHER'S N | | | _ | CDD | |
| TO BE CON | Michael | 11 | McC | 1oskey | | | | Anna | Mary | May | | | |
| TO E | 19a. INFORMANT'S NAME (Ty | | | | | | | nd Number or Rural | | | | | |
| 9 - | Charlotte W. | | , Esq. | | 1510 | Fide. | ity | Bldg. | 210 l | V. Char | cles S | St. (| 21201) |
| must | 20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremation | n 3 🗆 Remo | oval from Stata | | E AND DATE | | | | DAT | | CATION C | | |
| E | 4 ☐ Donation 5 ☐ Other (| | CAICCE | New | Cathed | | | CY Septe | | 6 Balt | imore, | Mary | land |
| E | an ordinarone of Forenac | 10th | Draw | 5 | - | | | hell-Wi | | eld Hon | ne. | | |
| ex _ | John G. | Reitz | | | | | 5500 | York Re | d. Ba | ltimor | ce, Ma | aryla | nd 21212 |
| medical examiner | 23. PART i. Enter the dis | seases, or c | complications the | t caused tha | daeth. Do | not anter | he mo | de of dying, au | ch aa can | diec or respi | retory arre | est, | Approximate Interval Between |
| | IMMEDIATE CAUSE (Fina | al | | | | | | | | | | | Onset and Death |
| event, the | disease or condition resulting in death) | → | n. Clery | drate | 77 | | | | | | | | ZWES |
| . 60 | | | DUE JO | nuttu | SEQUENCE O | F): | | | | | | | 2 months |
| other traumatic er | Sequantially list condition | | | (OR AS A CONS | | e. | | | _ | | | | I months. |
| or other traumatic | If any, leading to immed cause. Enter UNDERLYIN | NG | don | intea | JEGGENGE G | , ,. | | | | | | | |
| FI P | CAUSE (Disease or injur | у 🔰 ' | DUE TO | (OR AS A CONS | SEOUENCE O | F): | | | | | | | - |
| | resulting in death) LAST | r 🔃 | 1. | | | | | | | | | | |
| 5 0 | PART II Other elapificas | nt condition | s contributing to | doub but as | A | I- Ab | | | - | | | | 1 |
| = 4 | PART II. Other algnificer | condition | s contributing to | dasin but no | it resulting | in the unc | ertying | g cause given in | Part I. | 24a. WAS AN PERFOR | MED? | A | ERE AUTOPSY FINDINGS MILABLE PRIOR TO |
| MEDIC | V// | | | | | | | | | 1 TES 2 | XNO | | OMPLETION OF CAUSE F DEATH? |
| | DID TORACC | O LICE | CONTRIBUT | T TO 64 | LICE O | E DEAT | P1 1 3 | VEC () | | | | 1 | YES 2 NO |
| A S3 | DID TOBACC 25. WAS CASE REFERRED TO | | COMIKIBU | E IO CA | NUSE C | r DEA | | ACE OF DEATH (C | 0 🗆 | 1 | | | |
| SICI | EXAMINER? | | HOSPITAL: | EB/Outpetlant | 3 □ 00A | OTHER | | e 5 🗆 Raaldenca | | | | | |
| b > | 27. MANNER OF DEATH | | 28e. DATE OF | INJURY | 28b. TIA | IE OF | 28c, INJ | URY AT | 1 | SCRIBE HOW I | NJURY OCC | URED | |
| marked, BY PH | 11 24 | Pending reatigation | (Month, L | lay, Year) | IN | JURY | | RK? YES 2 NO | | | | | |
| BY BY | 2 Deutste | Could not be | 28e. PLACE (| F INJURY At | home, ferm, | street, facto | ry, office | | | ATION (Street a | and Number of | or Rural Rou | te Number, |
| | | | banaing, | atc. (Specify) | | | | | City | or Town, State) | | | |
| 28 is | 4 Homicide d | letarmined | | | | | | | | | | | |
| item 28 is | 29a. CERTIFIER 1 TO CERTIFIER | letermined | CIAN: To the best of | my knowledge, | death occurr | ed at the tir | ne, data | and place, end du | a to the ca | use(a) and mar | nner ea atate | d. | |
| If item 28 is | 29a. CERTIFIER (Check only | IFYING PHYSI | CIAN: To the best of a | | | | | | | | | | nd manner ee stated. |
| If item 28 is | 29a. CERTIFIER (Check only | IFYING PHYSICAL EXAMINE | R: On the beele of e | | | | | | e time, data | | d due to the | cause(a) a | nd manner ee stated. |
| IPORTANT: If Item 28 is BE COMPLETED | 29a. CERTIFIER (Check only one) 2 MEDIC | IFYING PHYSICAL EXAMINE | R: On the beele of e | xamination end/ | | | | eath occured at the 29c, LICENSE NU | e time, data | | d due to the | SIGNED (M | fonth, Day, Year) |
| TANT: If Item 28 II | 29a. CERTIFIER (Check only one) 2 MEDIC | IFYING PHYSIC CAL EXAMINE OF CERTIFIER PERSON WHO | R: On the beele of e | xamination end/ | or investigation | on, In my op | Inlon, d | 29c, LICENSE NU D-28987 | e time, data | end place, an | 29d, DATE | SIGNED (M | fonth, Day, Year) |

| DALI INCOE, MANILAND | cars after death. Page 6 may be retained by the hospi | ied in by the funeral director, page 5 should be detached | e medical examiner must be notified at once. | |
|--|--|---|---|--|
| DIVISION OF VITAL RECORDS, T.O. BOX 13148, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fined in by the funeral director, page 5 should be detached as the companient of removal. | De liter Willin 12 Hours are Death with the Date Copy. Or regular in her and provided and provided at once. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |

| - | FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND N CERTIFICATE OF DEATH | MENTAL HYGIE REG. N | |
|------|---------------------------------------|--|------------------------|-----|
| l. E | DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH | DAY |

| | 1 - STATE STATE REGISTRAR | IE UF MARYLAND | ERTIF | CATE O | F DEATH | MENIAL HYGIENE REG. NO. | | |
|--------------------|---|---|-------------------|---------------------------------|------------------------|--|---------------------|--|
| | 1. DECEOENT'S NAME (First, Middle, Last) | | | OATE O | | 2. DATE OF DEATH | | 3. TIME OF DEATN |
| | 1 ellia E. M | , 11 er | | | | MONTH DAY | 94 | 3.05 AH |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | 8. AGE (In yrs. | last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTN | | NPLACE (State or Foreign |
| | 245-64-8872 181 | 12 F 97 | YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) 3-/3-97 | 7 Coupt | "C · |
| | 9a. FACILITY NAME (If not institution, give street and | number) | | 9b. CITY, TOW | OR LOCATION OF D | | 9c. COUNTY OF D | DEATH |
| 5 | Pleasant Manor | Nurs. Cng | h. | Bal | to | | | |
| DIRECTOR | RESIDENCE OF DECEDENT | 7 | | | | | | Distriction of the second |
| 뿔 | 10a. STATE 10b. COUNTY | | 10c. CITY | r, TOWN OR LO | ATION | | | 10d. INSIDE CITY LIMITS? |
| | 10e. STREET AND NUMBER | | | | 101. ZIP CODE | | 10g. CITIZEN OF | 1 YES 2 NO |
| FUNERAL | | HS AUE | | | 21215 | - | log. CITIZEN OF | CA |
| R | 4615 Park Heig | DECEDENT EVER IN U.S. | ADMED | 12 WAS 0 | | NIC ORIGIN? (Specify Yes | OV NO 14 BAC | E — American Indian, |
| BY FU | 1 News Married 2 Married FOI | | NO | If yes, | | an, Puerto Rican, atc.) | Blac | k, White, atc. |
| | 15, DECEDENT'S EDUCATION | 16a. | DECEDENT'S | USUAL OCCUPA | TION | 16b. KIND OF BUSI | NESS/INDUSTRY | |
| E | (Specify only highest grade complete Elementary/Secondary (0-12) Colleg | d) e (1-4 or 5+) | (Give kind of w | vork done during e retired.) | most of working | | | |
| ם | 5th grade | | ta | rmer | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Lest) | | | | 18. MOTHER'S N. | AME (First, Middle, Maiden S | Surname) | |
| BEC | billard Miller | | | | Hes. | ter Pe | rry | |
| 10 | 19a. NFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street | t and Number or Rural | Route Number, City or Town, | State, Zio Code) | 1 2 1 212.5 |
| - | Lille Stank | (h) | 371 | + W. | Colds | pring Lan | e Dair | to, Md 21219 |
| | 20 METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify) | n State 20h. PLAC | E OF DISPOS | SITION INAMO OF | cometery crematory or | 100 Jay 200. 400 | eation — City or to | own, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | , , , | | 22. NAME | AND ADDRESS OF F | CILITY | | |
| | ► 400Tin 18/1 | ton) | | 143 | toh I- | H- West | Je) | |
| | 23. PART i. Enter the diaeases, or complic | ations that caused the | death. Do n | not enter the | node of dying, su | ch as cardiac or reapir | atory arrest, | Approximata |
| | shock, or heart fallura. List on | y one cause on each t | ne. | | | | | intarval Between Onset and Death |
| | iMMEDIATE CAUSE (Final disease or condition | CARDIAC | - F | FAILLUI | ZE | | | CON |
| | resulting in death) a | DUE TO (OR AS A CON | SEQUENCE OF | F): | | | | |
| z | | CAVLDION | 40P | AThy | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A CON | SECUENCE O | F): | | | | |
| S | cause. Enter UNDERLYING CAUSE (Disease or injury | ASCVI |) ' | | | | | |
| | that initiated avents | OUE TO (OR AS A CON | SEQUENCE O | F): | | | | |
| H | d | | | | | | | |
| | PART ii. Other significant conditions contr | ibuting to death but no | t resulting | in the underly | ing cause given in | Part 24a, WAS AN | | b. WERE AUTOPSY FINDINGS |
| S | CA | RCINOMA | | The | 114051 | ATE PERFORI | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| E | Oi | enne | 61 | 715 is | 71 | | | 1 YES 2 NO |
| | | | 11 | | | _ | | |
| PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | PLACE OF DEATH (C | heck only one) | | |
| Sic | 1100 | PITAL: patient 2 - ER/Outpatient | 3 🗆 DOA | OTHER: | ome 5 🗆 Residence | 6 Other (Specify) | | |
| H | | Ba. DATE OF INJURY (Month, Day, Year) | 28b. TIM | E OF 28c. | INJURY AT WORK? | 28d. DESCRIBE HOW IN | JURY OCCURED | |
| ВУ | 1, Natural 5 Pending 2 Accident Investigation | | 1 | | YES 2 NO | | | |
| | 3 Suicide 6 Could not be | Be. PLACE OF INJURY — At building, etc. (Specify) | home, farm, | street, factory, o | ffice | 261. LOCATION (Street a: City or Town, State) | nd Number or Rural | Route Number, |
| 1 | 4 Nomicide determined | | | | | | | |
| PLE | 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To | the best of my knowledge, | death occurr | ed at the time, o | ate and place, and du | e to the cause(a) and man | ner as stated. | |
| COMPLETED | one) 2 MEDICAL EXAMINER: On the | e basis of examination and | for investigation | on, in my opinio | n, death occured at th | e time, date and place, and | d due to the cause | (a) and menner as stated. |
| ш | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE N | MBER | 29d. DATE SIGNE | D (Month, Day, Year) |
| 0 | D/mique. | mo | | | 1448 | 29 | q | 1194 |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO COMP | LETED CAUSE OF DEATH (| . 0 | | D. 2 | 435 W | BELVE | dere Ave |
| | 31. DATE FILED (Month, Day, Year) | 2. REGISTRAR'S SIGNATUR | E P | 4. | | 7 | 54150 | 71210 |
| | 31. DATE FILED (Month, Day, Year) SEP 0 6 1994 | John Danden | Verytra | | | | | · 4-13 |
| _ | | - | | | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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|---|

| | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTI | | | MENTAL HYGIEN | | | | | |
|---------------|--|--|--|-----------------------------|---|--|---|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Inez M | 1. Michi | | | | 2. DATE OF DEATH | MAY Y | 3. TIME OF DEATH | | | |
| | 4. SOCIAL SECURITY NUMBER 2 \$ 2-24-8036 | 5. SEX 6. AGE (1 | F UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Dey, Year) 7 26 | | BIRTHPLACE (State or Foreign Country) irginia | | | | |
| DIRECTOR | | .FACILITY NAME (If not institution, give street and number) 30 (2 Presbury Street Baltimore | | | | | | 9c. COUNTY OF DEATH | | | |
| E C | 10e. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LOCAT | ION | | - | 10d. INSIDE CITY | | | |
| 품 | Mary1and | N/A | | Baltir | nore | | LIMITS? | | | | |
| FUNERAL | 100. STREET AND NUMBER 30 2 Presbury | Street | | 101. | 2 2 6 | | | CITIZEN OF WHAT COUNTRY? | | | |
| BY FUN | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 NO | If yee, spe | ENDENT OF HISPAI icity Cuben, Mexice 2 NO Specifi | Black, White, etc. Specify: Black | | | | | |
| | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 years 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWILE 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) | | | | | | | | | | |
| APLET | | | | | | | | | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Maider | Surneme) | | | | |
| H | Lindsey Quarl | Les | | | Ella | | | | | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) Kenneth Michie | 9 | 8 Air | way C | ircle | Route Number, City or Toe TOWSON, | vn, State, Zip Co Mary 1 | and 2/286 | | | |
| | 20e. METHOD OF DISPOSITION 1 | | PLACE AND DATE OF letery, crematory or other arvland | | | 9/9/94 10ria1 Pr | C. Lau | y or Town, State | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | | _ | | D ADDRESS OF FA | 5240 | | sterstown Rd | | | |
| | Devel Hos | 400 | | Chati | nan-Har | ris F/H | Balti | more, Md2/2/ | | | |
| | 23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory errest, ehock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Onset and Death Due To (or as a consequence or: | | | | | | | | | | |
| CERTIFICATION | disease or condition resulting in death) Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| MEDICAL | PERFORMED? A 1 YES 2 NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO | | | |
| | DID TOBACCO USE | CONTRIBUTE TO | CAUSE OF | DEATH Y | ES N | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 28. PL | ACE OF DEATH (Ch | eck only one) | | | | | |
| ΥS | 1 YES 2 NO | 1 Inpatiant 2 ER/Outp | atient 3 DOA 4 | ☐ Nursing Hom | | 8 Other (Specify) | | | | | |
| 2.7 | Natural 5 Pending | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME (| Y WO | JRY AT RK? ES 2 NO | 28d. DESCRIBE HOW | INJURY OCCUP | RED | | | |
| ED BY | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 28a. PLACE OF INJURY building, atc. (Spec | — At home, term, stre | | | 281. LOCATION (Street City or Town, Stell | and Number or | Rural Route Number, | | | |
| COMPLET | | CIAN: To the best of my knowl | | | | | | | | | |
| 8 | | | and/or investigation, | In my opinion, d | eath occured at the | time, date end place, e | nd dua to the c | cause(e) end menner ee stated. | | | |
| BE | B. SIGNATURE AND TITLE OF CERTIFIER | 1. MD | , | | 29c. LICENSE NUI | MBER (G) | 29d. DATE S | GIGNED (Month, Day, Year) | | | |
| P. | M. HAME, AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEA | ATH (ITEM 27) (Type, Pr | int) GRE, | 3NS | ST. E | ALT | ð. | | | |
| | 31. DATE FILED (Month, Day, Year) SEP 0 6 1994 | 32 AEGISTRAR'S SIGN | ATURE | | | | | | | | |

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| 5 | |

| | 1. DECEDENT'S NAME (First, Middle | a, Last) | | | | | | | 2. DATE OF | DEATN | | 3. | TIME OF DEATH |
|----------------------------|---|--|--|--|--|---|--|------------------------|---|---|-------------|------------------|----------------------------------|
| | ELIZABETH | M ARY | | Т | PI.ATT | | | | MONTH | 3.7 | | EAR | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In | yrs. last birthday) | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF | BIRTN | 9/ | BIRTHPLA | 7:25 PM ICE (State or Fore |
| , | 118-34-1217 | 1 □ M 2/2/2/F | 9. | 4 YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, De 8/31/ | 1900 | | Country) Germ | anv |
| | 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE | | | | | | | | | | | | |
| CTOR | NORTH ARUNDEL HOSPITAL ASSOCIATION GLEN BURNIE A.A. COUN | | | | | | | | | COUNTY | | | |
| DIREC | | COUNTY | | 10c, CI | Y, TOWN C | R LOCA | TION | | | | | 100 | d. INSIDE CITY LIMITS? |
| | - | Anne Arunde | 1 | Pa | sader | na | | | | | | 1 { | YES 2XXN |
| AAL | 100. STREET AND NUMBER | , | | 10 | f. ZIP CODE | | | 10 | | | T COUNTRY? | | |
| NER | 8251 Baltimos | | | | 100 | | 211: | | | | USA | | |
| BY FUNE | 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 YES | | | | | | No- 14. | Black, W Specify: | | | | |
| G | 15. DECEDENT'S EDUCATION 16. | | | | Be. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/IND | | | | | ESS/INDUST | TRY | White | |
| LETE | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | | (Give kind of work done during most of working life. Do NOT use retired.) | | | | | | | | | |
| COMPL | Unknown | Hom | Homemaker | | | | | House | ewife | | | | |
| | 17. FATHER'S NAME (First, Middle, L. | ast) | N.A. | over. | | | 18. MOTH | IER'S NAM | AE (First, Midd | le, Maiden Sun | name) | | |
| BE | 19a, INFORMANT'S NAME (Type/Prin | -01 | M | eyer | | | | | | | | | |
| 2 | Mr. John Platt | RD # | | | | | | City or Town, S New | | | 2066 | | |
| | 20a. METHOD OF DISPOSITION | | 20h D | LACEANDDATE | | _ | | Lope | DATE | 20c. LOCAT | | | |
| | 1 Buriel 2 Cremation 3 4 Donation 5 Other (Specific | | cemet | ery, crematory or Vince | other place) | | | am. | | | | | ew Yor |
| | 21. SIGNATURE OF FUNERAL SERV | | | Ecker | 22. | NAME A | NO ADDRES | SS OF FAC | HITY | | | | ew ior |
| 1 | • 4 | 85/2 | | TAN 201 | Mo | Cul | Ly Fu | nera | al Hom | e of I Pasade | Pasad | ena | 21122 |
| \dashv | 23. PART I. Enter the disease | es, or complications th | at caused t | the death Do | | | | | | | | | 21122 |
| | 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter tha mode of dying, such ea cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | ' | interval Bo | | | |
| | iMMEDIATE CAUSE (Final disease or condition | G | ة أحاء | · el a | 1. | | | | | | | | -) |
| } | resulting in death) a. Due To (or As A CONSEQUENCE OF): | | | | | | | | de C | | | | |
| z | 011 1:15 1 1 1 | | | | | | | | | | | | |
| 일 | Sequentially list conditions, if any, leading to immediate Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| FICATION | cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | | | | | |
| # | that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| CERT | | d | | | | | | | | | | | |
| CAL | PART ii. Other significant cor | | | | | derlyln | g cause g | jiven in l | Part i. 24 | e. WAS AN AU | | | RE AUTOPSY FI |
| | Dementio | | olhyr | richs | m; | Al | w | | _ 1 | YES 2 | 1 | CO | MPLETION OF O |
| MED | Filmiller | hoin e | how | me e | din | a | 87 C | 31 | _ | , | 1 | | YES 2 |
| ~ | | , | | | | | 1 | 1- | | | 110 | | |
| | | | | | | 26 0 | LACE OF D | EATH (Cha | ck only one) | | | | |
| | 25. WAS CASE REFERRED TO MEDI EXAMINER? | HOSPITAL: | | | OTHER | | | | | | | | |
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| PHYSICIAN: | EXAMINER? | HOSPITAL: 1 2 inpatient 2 28s. DATE C | | 26b. TII | 4 🗆 Nun | R: ping Hon 26c. IN. W | ne 5 □ Re JURY AT DRK? | sidence | 6 Other (S | BE NOW INJU | JRY OCCUR | ED | |
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| ED BY PHYSICIAN: | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pendin Investly 3 Suicide 8 Could 4 Nomicide 6 Could 4 Somicide 6 Could Check only 1 CERTIFYING | HOSPITAL: 1 Anpatiant 2 28a. DATE C (Month.) gation not be hined 28a. PLACE building | OF INJURY Day, Year) OF INJURY — g, etc. (Specify of my knowled | At home, larm, | 4 Nun ME OF JURY M street, fact | R: sing Hon 26c. IN. W 1 ory, office | JURY AT DRK? YES 2 2 | NO and due | 8 Other (S) 28d. DESCRI 28d. LOCATIC City or R | DN (Street and own, State) | Number or I | Rural Route | |
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3. TIME OF DEATH

P

REG. NO.

FOR STATE REGISTRAR

t. DECEDENT'S NAME (First, Middle, Last)

1 -

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

2. DATE OF DEATH D9 Gilbert Peterson 35 02 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS 09-2033 MONTHS DAYS HOURS MIN 1 🕅 M 2 🗆 F filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR gnes RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? t YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 21223 Hue ours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 1 YES 2 □ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or NoIf yes, specify Cuben, Mexican, Puerio Rican, etc.)
1 YES 2 NO Specify: 14. RACE — American Indien Black, White, etc. 1 Never Merried 2 Merried ВҰ Specify: Black 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondery (0-12) College (t-4 or 5+) Sethlehen 84 be notified at once. 17. FATHER'S NAME (First, Middle, Last 18. MOTHER'S NAME (First, Middle, BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Str. 2 21223 9 DATE 20e. METHOD OF DISPOSITION 205. PLACE AND DATE OF DISPOSITION (Name of 20c, LOCATION must Burlel 2 Cremation 3 Removal from State

Donetion 5 Other (Specify) medical examiner 21. SIGNATURE OF FUNEBAL SERVICE LICENSEE 22, NAME AND ADDRESS OF cremation, or removal 23. PART I. Enter the diseases, or complications that caused the death. Oo not enter the mode of dying, such as cardiac or shock, or heart fellure. List only one ceuse on each line. Approximate Interval Between Onset and Death IMMEDIATE CAUSE (Final other traumatic event, the disease pr condition_ Myocannia ture INFARCTION 2 DAYS this certificate has been signed by the attending physician and completely with the State Dept. of Health and Mental Hygiene prior to burial, cremating resulting in death) HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially liet conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated evente reaulting in death) LAST ŏ PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 23 shows any 1 TYES 2 NO OF DEATH? 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🗆 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28, PLACE OF DEATH (Check only one) Hem HOSPITAL 1 YES 2 NO OTHER:
4 Nursing Home Inpetient 2 - ER/Outpetient 3 - DOA marked, or 27. MANNER OF DEATH 28e, DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Netural Pending investigation BY 1 YES 2 NO FUNERAL DIRECTOR: After within 72 hours after death 2 Accident 28s. PLACE OF INJURY — Al home, Ierm, street, fectory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) Sulcide 28 is COMPLETED 6 Could not be Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTE be filed within 72 hours aft IMPORTANT: If Item 28 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(e) end manner se stated (Check only one) 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE an 36336 215 mo 2 ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ST HOSPITAL Fredericic AGNES UN 32 EGISTRAR'S SIGNATURE

in Dender

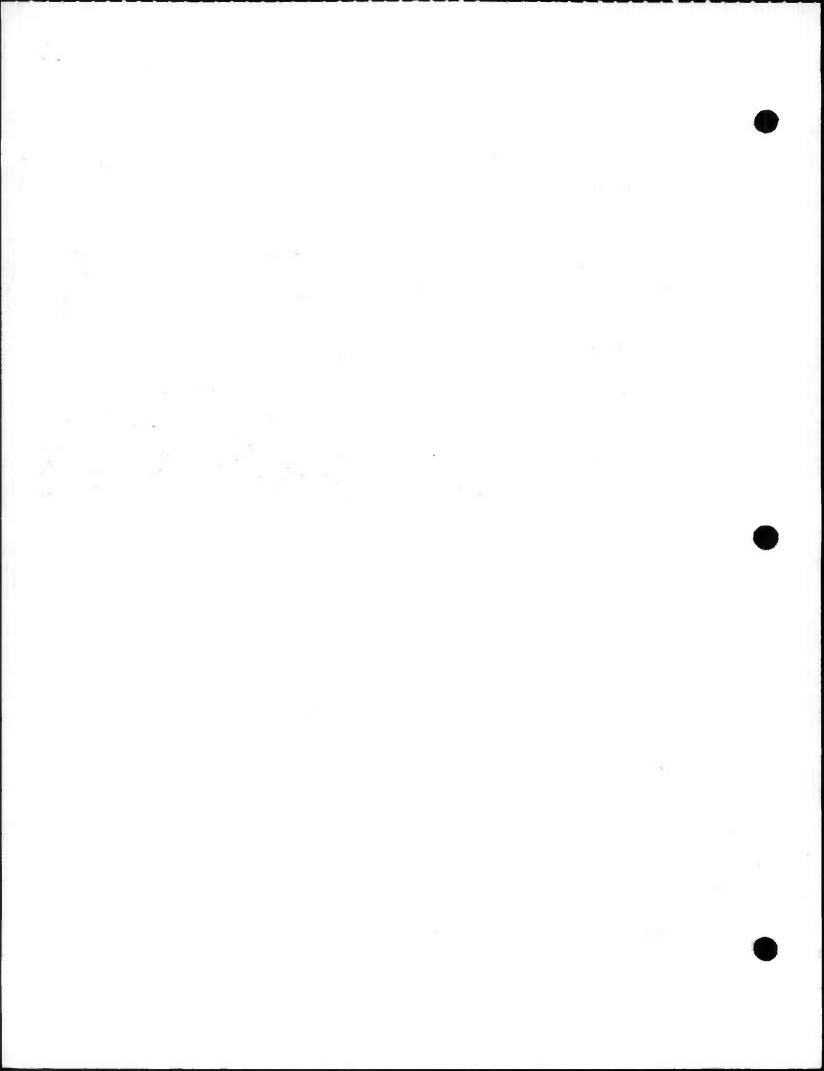
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

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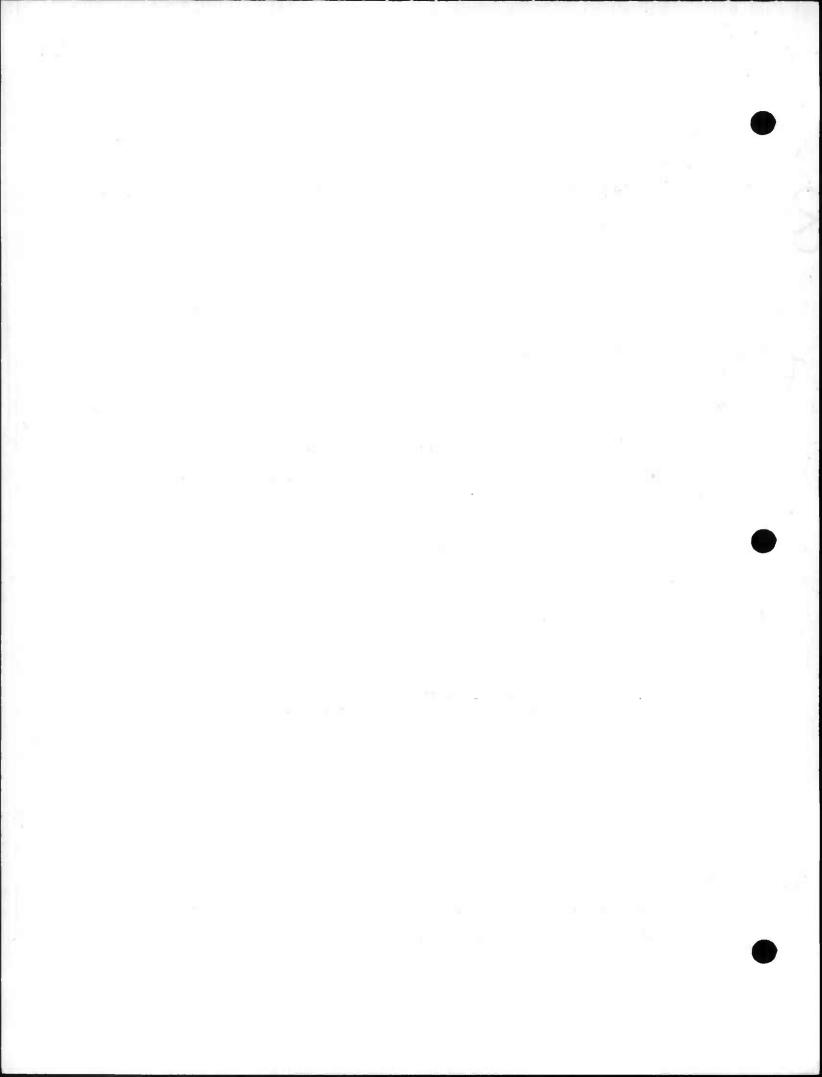
| 1 | 1. DECEDENT'S NAME (First, Middle, L | 7.07 | | 2. DATE OF DEATH WORTH , DAY | VEAR 3. TIME OF DEATH |
|----------------------------|--|--|---|--|---|
| | | NN PERRY | | | 94 21501 |
| В | 4. SOCIAL SECURITY NUMBER 211-90-5550 Sa. FACRITY NAME (IF HAS INSERTION, S. Union, Memor | 2 s. sex 1 m s X F 29 vrs. 2 vrs. 1 al Hospital | Baltimore Ci | ATH SECOUNT | BIRTHPLACE (State or Foreign V OF DEATY / WY) |
| ривестоя | RESIDENCE OF DECEDENT | r | TY, TOWN ON LOCATION | Ly | 104. RESIDE CITY |
| | 104 STREET AND NUMBER | Bul at | 101. ZIP CODE | 10g. CITIZE | 1 N YES 2 IN NO |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ADMED FONCEST 1 YES 2 NO IF YES, GIVE WAR OR DAYES | 13. WAS DECEMBENT OF HISPAU If yes, specify Cuben, Mexico 1 — YES 2 MO Specif | n, Puerto Ricen, etc.) | 4. RACE — American Indian, Black, White, etc. |
| COMPLETED | 15. DECEDENT'S (Specify only highest ; Elementaryslopindary (Mg)) | EDUCATION 15a. DECEDENT (Give kind of the Decedent (Give kind of the De NOT) | S USUAL OCCUPATION I work dove during most of working use retried.) | 166, KIND OF BUSINESS/INOU | striv |
| BE COM | 17. FATHERS HAME (FOR, MICHIEL LOSS | ERRY | Tun | ME (First, Missie Maidenglurrame) | 5 |
| 10 | 200 METHOD OF DISPOSITION | 11/1/90N 12 | 2 - CE DESIPOSITION Mame of | PATE TOO LOCATION - CH | MD, 2121 |
| | 1 Burisi 2 Crementor 3 1 County County 21. SIGNATURE OF SUPERAL SERVICE | Removal from State | 22. NAMO AND ADDRESS OF S | 19194 Janeson | HONE TO |
| | shock or heart fails IMMEDIATE CAISE (Final disease or condition resulting in death) | or complications that caused the death. Do use. List only one cause on each line. A I D S DUE TO JOR AS A CONSEQUENCE OF | teromoner (il con interveniment estatem nesse r | n an Caronac of Feispiratory arres | Onset and D |
| | The state of the s | SCROLS | | | |
| RTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSE | OF): | | 17 ho |
| DICAL CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF | URE | PRIT I. 24s. WAS AN AUTOPSY PERFORMED? | 17 ho |
| MEDICAL | If any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant cond ANGMINISTRACTOR IN | DUE TO (ON AS A CONSEQUENCE OF LIVER FAIL LIVER FAIL Itions contributing to death but not resulting | In the underlying cause given in | 1 YES 2 NO | 2 MEE 248. WERE AUTOPSY FINDS AMILABLE PRIOR TO COMPLETION OF CAUS |
| PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant cond. AN EMIP DID TOBACCO USE CO 21. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | DUE TO (OR AS A CONSEQUENCE OF | ES NO UNCERTAIN ATH (Check only one) OTHER: 4 Nursing Home 5 Residence | 1 YES 2 NO | 2 WEE 240. WERE AUTOPSY FINDS AMALABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 VES 2 2000 |
| ED BY PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant cond. AN EMIP DID TOBACCO USE CO 21. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigate 1 Suintife 5 Could not determine | DUE TO (OR AS A CONSEQUENCE OF | ES NO W UNCERTAIN ATH (Chack only only) OTHER: 4 Nursing Home 5 Residence ME OF 28c. (NAJBRY AT WORKY) M 1 YES 2 NO | PERFORMEDY 1 YES 2 NO C Other (Specify) | 2 WEE 249. WERE AUTOPSY FIND AMALABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 VES 2 NO |
| BY PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant cond. A N E M I M DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigate investigate a Homicide determine 28s. CERTIFIER (Check only 1 Certififying P (Check only 1 MEDICAL EXAMINER) | DUE TO (OR AS A CONSEQUENCE OF LOCAL DUE TO (OR AS A CONSEQUENCE OF DUE TO (OR AS A CONSEQUEN | TO THE RESEARCH TO THE RESIDENCE OF THE | PERFORMED? 1 YES 2 NO 6 Other (Specify) 26d. DESCRIBE HOW INJURY OCCUR 28f. LOCATION (Street and Mumber or City or Iben, State) to the cause(s) and manner as stated time, date and place, and due to the couse(s) | COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO RED RED Rural Route Murrice; Cause(a) and manner as state |
| ETED BY PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant cond. A N E M I PA DID TOBACCO USE CO 21. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigate 1 Nomicide determine 2 Accident Investigate 1 Could not determine 28s. CERTIFIER CHOICE PROCESS OF THE COULD NOT THE COULD NOT THE COULD NOT THE COULD NOT THE CERTIFIER COULD NOT THE CERTIFIER SUBJECT OF CERTI | DUE TO (OR AS A CONSEQUENCE OF DEATH YOUR TO (OR AS A CONSEQUENCE OF DEATH YOUR PAIR OF DEATH YOUR PAIR OF DEATH YOUR PAIR OF DEATH YOUR PAIR OF DEATH YOUR PAIR OF DEATH YOUR PAIR OF DEATH YOUR PAIR OF DEATH YOUR PAIR OF DEATH YOUR PAIR OF DEATH YOUR PAIR OF DEATH YOUR PAIR OF DEATH YOUR PAIR OF DEATH YOUR PAIR OF DEATH YOUR PAIR OF DEATH YOUR PAIR OF THE PAIR OF | TO THE RESEARCH STORY AND STORY MEDICAL STORY OF THE RESEARCH STORY MEDICAL STORY MEDICAL STORY AND STORY MEDICAL STORY AND STORY AT WORKY MEDICAL STORY OFFICE STORY AND STORY AT WORKY MEDICAL STORY OFFICE STORY OFFI OFFI OFFI OFFI OFFI OFFI OFFI OFF | PERFORMEDT 1 YES 2 NO Compared to the compar | 177 ho |



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| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with | E LINERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled | K | FANT: If tem 28 is marked, or item 23 shows any injury, or other traumatic event, the m |
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| ained by the hospital or attending physician. | r this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should | | iffed at once |
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| runcate p | ig physici | liene prior | arked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified |
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| | FOR 1 - STATE REGISTRAR | STATE OF MARYLAND | DEPARTM ERTIFICA | | | MENTAL | HYGIENE REG. NO. | | | |
|---------------|--|---|---|----------------------------|---|-----------------|-----------------------------------|---------------------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | 2. DATE O | F DEATN | | 3. TIME OF DEATN | |
| | CHARLES W | 11111 | IWAY | | | 9 9 | 3 | 94 | 12:35 A M | |
| | | SEX 6. AGE (In yrs. la: | 8400 | UNDER 1 YEAR | IF UNDER 24 HRS. | | Day, Year) | a. BIF | THPLACE (State or Foreign intry) | |
| | 220 18 4125 1 9a. FACILITY NAME (If not institution, give street | X ^{M 2 □ F} 66 | YRS. | | R LOCATION OF D | | | | RGINIA | |
| TOR | DVA MEDICAL CENTER RESIDENCE OF DECEDENT | EATH | 9c. COUNTY OF DEATH BALTIMORE | | | | | | | |
| DIRECTOR | MARYLAND 106. COUNTY | a | ALTIM | TION E | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | | |
| FUNERAL | 100. STREET AND NUMBER 1656 NORM | AL AVENUE | | 101. ZIP GODE 2 1 3 | | | | | WHAT COUNTEY? | |
| B⊀ | 11. MARITAL STATUS 1 Never Married 2 Natural State St | . WAS DECEDENT EVER IN U.S. AF FORCES? X X YES 2 D IF YES, GIVE WAR OR DATES A I R F O R | NO | If yea, spe | ENDENT OF NISPA city Cuban, Maxico 2 NO Specifi | en, Puerto Ri | | 81 | CE — American Indian, ack, White, atc. | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade communication of the ollege (1-4 or 5-1) | ECEDENT'S USU Bit to kind of work DO NOT use ref ABORE | done during mos tired.) | N I of working | | TH ST | SHIPYARD) | | |
| BE CON | 17. FATNER'S NAME (First, Middle, Last) GEORGE PE | TTIWAY | | < | 18. MOTHER'S NA | AME (First, Min | MOOR E | eme) | | |
| 10 B | 19e. INFORMANT'S NAME (Type/Print) MARY A. | PETTIWAY 19 | 1656 | NORI | MAL A | Fourte Number | BAL | TMOR | E,MD 21213 | |
| | 20a. METNOD OF DISPOSITION XIX Burial 2 Cremation 3 Ramoval 4 Donation 5 Other (Specify) | | AND DATE OF DI | | | CEME | | ON — City or | Town, State SMILLS, MD | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENS | | th' | 22. NAME AN | D ADDRESS OF FA | ACILITY | | | NORTH AVE. | |
| | 23. PART I. Enter the discuses, or com shock, or heart fellure. List | plications that caused the de only one cause on each line | eath. Do not | enter tha mod | le of dying, suc | h sa cerdi: | c or respirato | ry srreat, | Approximate Interval Between | |
| | IMMEDIATE CAUSE (Final disease or condition as SEPTIC SHOCK | | | | | | | | | |
| | a | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| N | Sequentially liet conditions, UROSEPSIS | | | | | | | | | |
| ATI | DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury that initiated eventa resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| AL C | PART II. Other eignificent conditions co | ontributing to deeth but not | reculting in th | he underlying | ceuse given in | Part I. | 14a. WAS AN AUTI | OPSY 2 | 4b. WERE AUTOPSY FINDINGS | |
| MEDICA | _ RENAL INSUFFICIE | NCY | | | | | PERFORMED | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| | UPPER GASTRO INT | | | FARIL M | | | | | 1 _ YES 2 _ NO | |
| PHYSICIAN: | DID TOBACCO USE CO | NIKIBULE 10 CAU | SE OF D | | S NC | | | | | |
| SICI | EXAMINER? | OSPITAL: Vinpstlant 2 - ER/Outpetlant 3 | | THER: | 5 Residence | | (Paradia) | | | |
| Н | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIME OF | 28c. INJU | JRY AT | 1 | RIBE HOW INJUR | Y OCCURED | | |
| ВУР | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJURY | | ES 2 NO | | | | | |
| | 3 Suicide 8 Could not be 4 Homicide detarmined | 28e. PLACE OF INJURY — At he building, etc. (Specify) | ome, farm, stree | t, factory, offica | | | TON (Street and N Town, State) | lumber or Run | Il Route Number, | |
| COMPLETED | | t: To the best of my knowledge, do | | | | | | | e(a) and manner as stated. | |
| TO BE | 296. SIGNATURE AND TITLE OF CERTIFIER. | in m | | | 29c. LICENSE NU | MBER 98 | 290 | DATE SIGN | 3 9 4 | |
| F | DR. MARCOS GALICIA, | | | | , FORT H | HOWARD | , MARYI | AND 2 | 1052 | |
| | 31. SEP 0 6 1994 Ju | 32. REGISTRAR'S SIGNATURE | ٠. | | | | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760

| AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hospital or attending physician. | AL DIRECTOR: After this cardificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit perm? 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | |
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31. DATE FILED (Month, Day, Year) SEP 0 6 1994

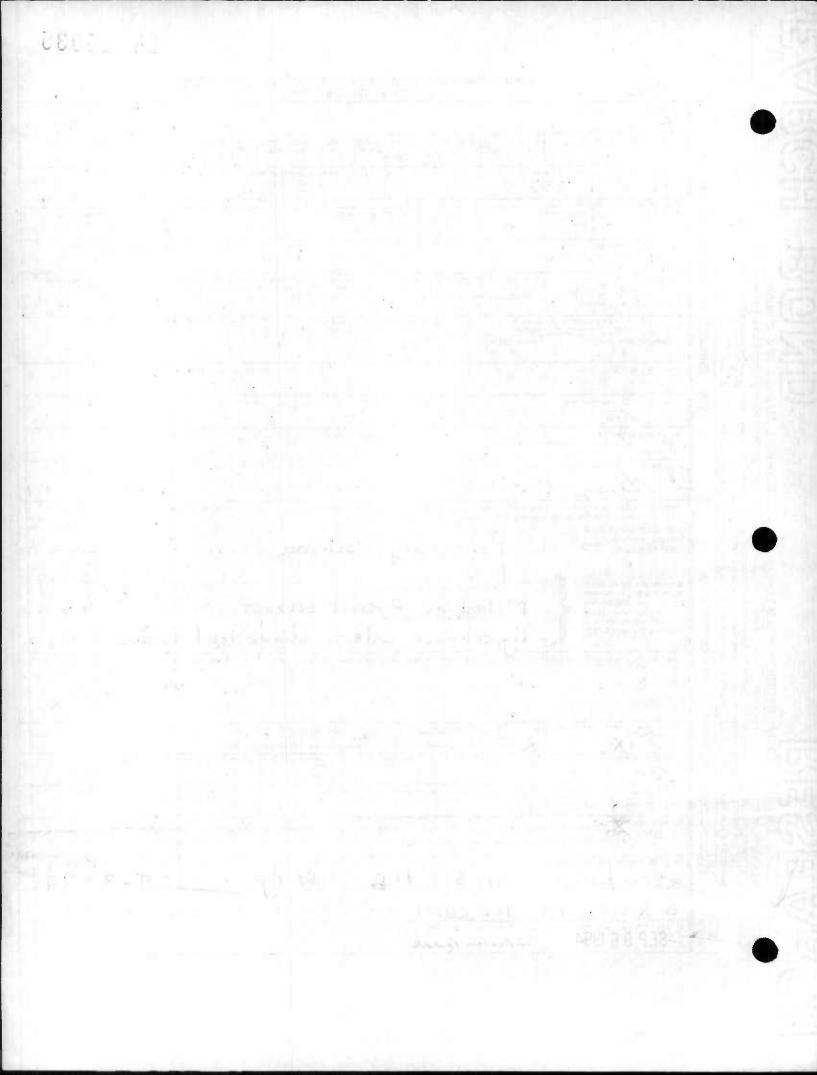
32. REGISTRAR'S SIGNATURE in Finden-Ro

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH
8:45 a. M 2. DATE OF OEATH Laine 0 4. SOCIAL SECURITY NUMBER B. AGE (in yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS HOURS 227-26-4620 1 M 2 1 YRS Virginia 9a. FACILITY NAME (If not institution, give stree 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH N/A St. Agnes Hospital Baltimore DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c CITY TOWN OR LOCATION 10d. INSIDE CITY Maryland N/A Baltimore 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 2 1 2 2 5 10g. CITIZEN OF WHAT COUNTRY? 28/0 Carver Road USA 11. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married YES 2 NO Specify: BY 3 XWidowed 4 Divorced Specify: Black. 16a. DECEDENT'S USUAL OCCUPATION

**China kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Sp (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) File Clerk Federal Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Roscoe Boone Bessie Smith BE notified 19a. INFORMANT'S NAME (Type/Print) Maryland 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2829 Bookert Drive Baltimore, 2 Tijuana L. Woodfork pe 20a. METHOD OF DISPOSITION

1 Burial 2 Cremation 3 Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of 9/8/9 must 4 Donation 5 Other (Specify) Zion Cemetery Baltimore, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY 5240 Reisterstown Rd F/HBaltimore, Md 2/2/ uris Chatman-Harris medical 23. PART I. Enter the diseases or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or raspiratory arrest, shock, or heert feliure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final disesse pr condition_ the state of Pulmonary
DUE TO (OR AS A CONSEQUENCE DE): resulting in death) odema -48hx Preumonia CERTIFICATION Sequentisity that conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leeding to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): BocanT CAUSE (Disease or Injury that initieted events resulting in death) LAST perlensive arleno sc PART II. Other significant conditions contributing to deeth but not reaulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? 1 TES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: **EXAMINER?** OTHER:
4 □ Nursing Home 5 □ Rasidence 6 □ Other (Specify) 1 TES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 27. MANNER OF DEATH 28a. DATE OF INJURY 26c, INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF Natural Accident 5 Pending Investigation 1 YES 2 NO BY 26s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town State) 6 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER (Check only one)

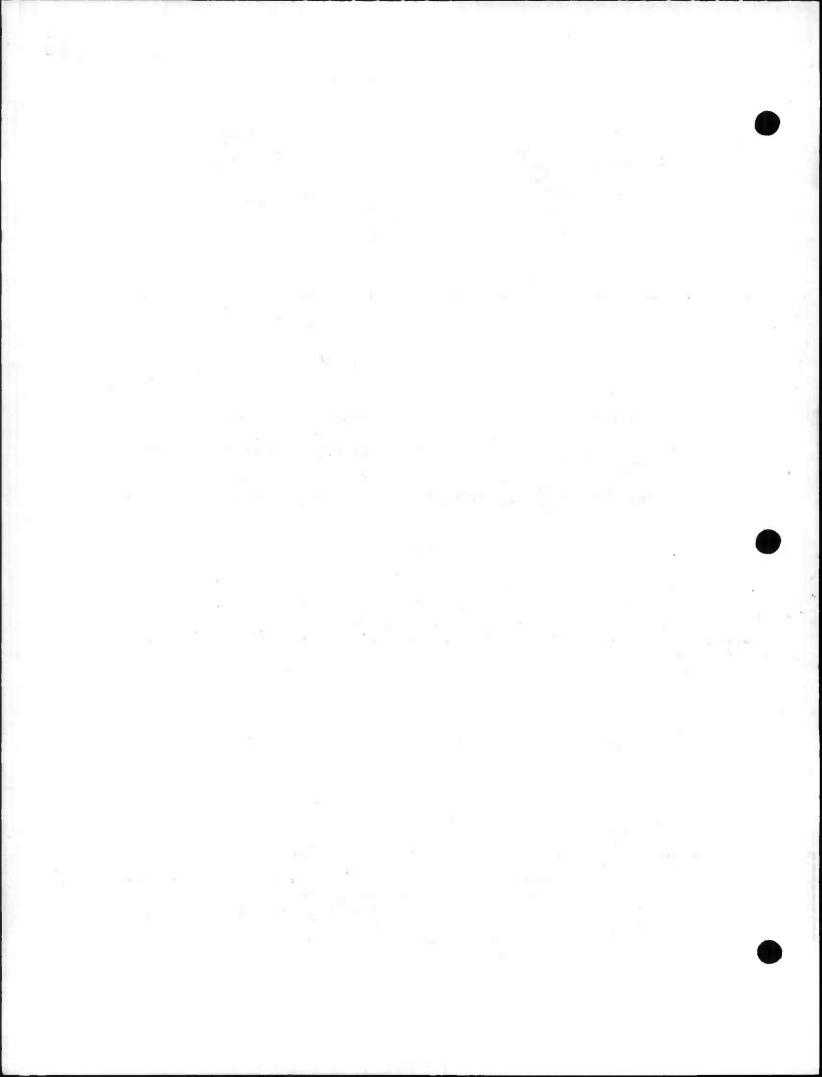
29 CERTIFING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examin TO THE HOSPITA
TO THE FUNERA
De filed within 7. FUNERA within 7 ation and/or investigation, in my opinion, death occured at the time, data and place, end dua to the cause(a) and manner as stated 296. FIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE acauam. S + Agres M.D 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S. &IVASAILAH 900 cator ave, Baltinione MD-21229



DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. |
|---|
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should |
| be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| |

| | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPART CERTIFIC | | | MENTAL HYGIEN | | | | |
|------------------|--|--|--|--|--------------------|---|------------------|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | |
| | Nelson Clyde | Reed | | | | August of | 28 199 | 4 2309 m | | |
| | 4. SOCIAL SECURITY NUMBER | OCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIR | | | | | | DIRTNPLACE (State or Foreign country) | | |
| | 219-20-4724 9a. FACILITY NAME (If not institution, give str | 219-20-4724 1 X M 2 F 67 YRS. MONTHS DAYS HOURS MIN. 04/23/27 B. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH | | | | | | aryland | | |
| DIRECTOR | Washington County | Hager | | | | Washington | | | | |
| EC. | 10e. STATE 10b. COUNTY | 10c. CITY, | TOWN OR LOCAT | ION | | | 10d. INSIDE CITY | | | |
| | Maryland Washin | ngton | Big | Pool | | | | LIMITS? 1 YES 2 X NO | | |
| AL | 10e. STREET AND NUMBER | | | 10f. ZIP CODE | | | | 10g. CITIZEN OF WHAT COUNTRY? | | |
| FUNERAL | 11725 Ernestville | | | 2 | 1711 | | USA | | | |
| | 11. MARITAL STATUS 1 Never Married 2 A Merried | 12. WAS DECEOENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DE | 2 X NO | If yes, spe | city Cuban, Mexica | NIC ORIGIN? (Specify Yearn, Puarto Rican, etc.) | | RACE — American Indian, Black, White, atc. | | |
| D BY | 3 Widowed 4 Divorced | | | | 2 NO Specify | | | white | | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) | Completed) College (1-4 or 5+) | (Give kind of wo | SUAL OCCUPATION rk done during mo- retired.) | N st of working | 16b. KIND OF BUS | SINESS/INDUST | RY | | |
| 됩 | 8 | 0011000 (1-2 01 0 17) | Machine | Operato | r | County | Govern | ment | | |
| S | 17. FATNER'S NAME (First, Middle, Last) | | | | 18. MOTNER'S NA | ME (First, Middle, Meiden | Sumame) | | | |
| BE (| Samuel Reed | | | | Rebecc | a McCormi | .ck | | | |
| ဝ | 19a. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or Town | | | | |
| | Vergie M. Reed | | | | | Big Pool, | | 21711 | | |
| | 20e. METNOD OF DISPOSITION 1 ↑ Burlel 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify) | wal from State | PLACE AND DATE OF Notice of Country of Country Of Count | DISPOSITION (Na (C) place) Lemeters | | 31/94 Big | POOT. | | | |
| 1 | 21. PIGNATURE OF FUNERAL SERVICE LICE | | idilitoo iiii | | | Home P.O. | 1001, | narytana | | |
| | 1 Dice | () | ٠ | | | Home P.O. ceet Hancoo | | | | |
| | 23. PART I. Enter the diseases, 60 co | omplications that caused | the death. Do no | t anter tha mo | de of dying, suc | h as cardiac or reapi | ratory arrest, | Approximata | | |
| ı | shock, or heart failure. I IMMEDIATE CAUSE (Final | .ist only-one cause on a | ach line. | | | | | Interval Between Onset and Death | | |
| | disease or condition resulting in death) | ــــــــــــــــــــــــــــــــــــــ | ndden C | andrice | Derl | ス | | | | |
| | | DUE TO (OR AS A | consequence of: | | | | | | | |
| 8 | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE FORDERS FORDE | | | | | | | | | |
| ¥ | if any, leading to immediate cause. Enter UNDERLYING | | Anterior | eleration | Gendric | made | mean | <u> </u> | | |
| Ĕ | CAUSE (Disease or injury that initiated events | | CONSEQUENCE OF): | | | | | | | |
| CERTIFICATION | reaulting in death) LAST | l | | | | | | | | |
| AL C | PART ii. Other significant conditions | contributing to death b | ut not reaulting in | the undariying | cause given in | Part I. 24s. WAS AN | AUTOPSY | 24b. WERE AUTOPSY FINDINGS | | |
| 2 | Dishts Me | Minter | | | | PERFOR | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | |
| ME | | | | | | | | OF DEATN? | | |
| PHYSICIAN: MEDIC | | | | | | | | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | ACE OF DEATH (Ch | eck only one) | | | | |
| YSI | 1 TYES 2 THO | 1 Inpetient 2 ER/Outp | | OTHER: - Nursing Hom | 5 🗆 Residence | 8 Other (Specify) | | | | |
| F | 27. MANNER OF DEATN 1 | (Month, Day, Year) | 28b. TIME INJUI | YY WO | RK? | 28d. DESCRIBE NOW I | NJURY OCCURE | ED | | |
| BY | 2 Accident Investigation | | | | ES 2 NO | | | | | |
| COMPLETED | 3 Suicide 6 Could not be determined | 28e. PLACE OF INJURY building, atc. (Spec | — A1 home, farm, str city) | ee1, factory, office | · | 28f. LOCATION (Street a City or Town, State) | ind Number or A | ural Route Number, | | |
| ٦ | 290. CERTIFIER | CIAN: To the best of my know | ledge death occurred | at the time date | and place, and due | to the causele) and mas | | | | |
| OME | | R: On the basis of examination | | | | | | use(e) end manner ee stated. | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUI | MBER | 29d. DATE SIG | GNED (Month, Day, Year) | | |
| TO BE | 1 | ant no | | | 2 (80) | 9 | ▶ 9. | 694 | | |
| = | 30. NAME AND ADDRESS OF PERSON WHO | | | | GERST | 10WV ~ | 9 2 (| . > 4 0 | | |
| | 31. 9 E-P=0 6. 1994 | 32. REGISTRAR'S SIGN | ATURE | | | | | | | |
| | 011 0 0 1994 | and Dendem-Re | | | | | | | | |
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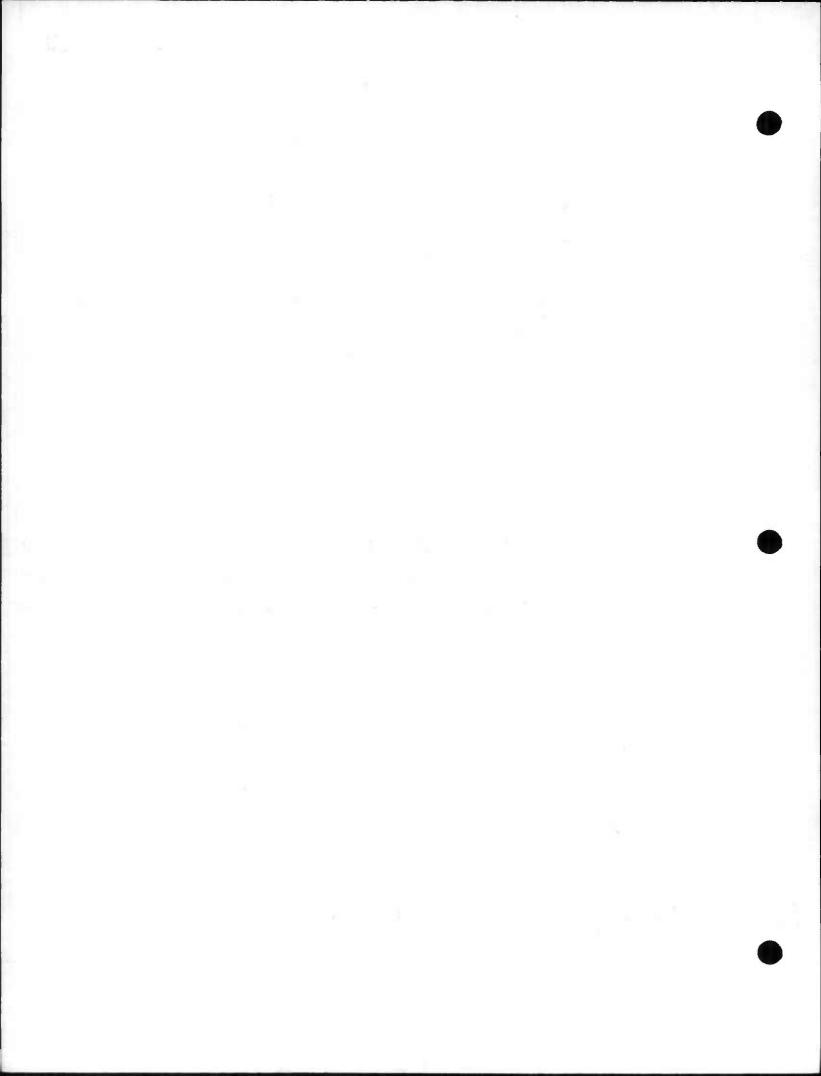


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| ICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician. | cate has been signed by the attending physician and completely filled it | with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | s is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| The law | nte has by | ate Dept. | ет 23 |
| SICIAN | certifical | the Sta | I, or ite |
| IS PHY | OR AME THIS CONTIN | death with | marked |
| END | DR A | ther de | 11 10 |
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| | 1 - FOR STATE OF REGISTRAR | MARYLAND / | | TMENT ICATE | | | | | TYGIEN | _ | | |
|----------------------|---|-------------------------------------|----------------------------|---|----------|-------------------|------------|------------------------------------|-------------|--------------|---------------------------|---|
| | 1. OECEDENT'S NAME (First, Middle, Last) 4. SOCIAL SECURI NUMBER 5. SEX | Ripple | | | | | | 2. DATE OF | m hop- | 3 | 9 ⁴ 4 | 3. TIME OF DEATH 4.05 P M |
| | 219-16-5933 1 D M 2 🕮 F | 6. AGE (In yrs. les | YRS. | | DAYS | IF UNDER | MIN. | 7. DATE OF (Month, D 05 | 25°2 | 23 | 8. BIRTH Countr MAF | PLACE (State or Foreign |
| TOR | 9e. FACILITY NAME (If not institution, give street and number) GOLDEN OAKS NURSING RESIDENCE OF DECEMENT | 96. CITY, 1 | | REL | ON OF DE | ATH | | 9c. COUNTY OF DEATH PRINCE GEORGES | | | | |
| DIRECTOR | 100. STATE 10b. COUNTY MARYLAND ANNE ARUI | NDEL | 10c. CIT | Y, TOWN OR | | | ARK | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 PNO |
| FUNERAL | | | | | | | | HAT COUNTRY? | | | | |
| В | 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: WHIT | | | | | | | — American Indian, White, etc. | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) L 2 College (1-4 or | (Gi | ive kind of a Do NOT us | usual occ work done du sa retired.) EWIF | ring mos | N it of workin | g | 16b. K/ | HON | MEMA | | |
| BE CO | 17. FATHER'S NAME (First, Middle, Last) ANDREW GRIMES | | | | | M | ARGA | AE (First, Midd ARET | A. I | DeMA | | |
| 2 | JACK W. RIPPLE | (| 500 | SALT | ZMA | NN . | | oute Number, O-SEV | | | | D.21146 |
| | 20a. METHOD OF DISPOSITION 1 X Burlet 2 Cremetion 3 Removal from State 4 Donation 5 Other (Death) | 20b. PLACE | | D' P'VE' | TER | ANS | | 9/7 | | | VILI | JE, MD. |
| | · Lay 1. A | . oufm | an | | | | C. IN H | | FUN. | JERA SLEN | L HO | ME 21061 RNIE,MD. |
| | 23. PART I. Enter the diseases, of complications to shock, or haart failure. List only one community in the complex condition resulting in death) | nat caused the de ause on each line | · ~ | | ha mod | fa of dyl | ng, such | ss cardiac | or reapi | retory sn | rest, | Approximate Interval Between Onset and Death |
| ERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or Injury | O (OR AS A CONSEC | | | | | | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other significant conditions contributing | | | in the und | arlying | causa g | ilven in f | | PERFOR | MED? | 24b. | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| AN: M | 25. WAS CASE REFERRED TO MEDICAL | | | | | | | | | | | 1 PES 2 NO N/A |
| IYSICI | EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 | ☐ ER/Outpatient 3 | | 7 | ng Home | 5 🗆 Re | | ck only one) 8 Other (S | oecify) | | | |
| ву Рн | 1 Netural 5 Pending (Month, | Day, Year) | | M | | ES 2 | NO | 28d. OESCR | BE HOW II | AURA OC | CUREO | |
| ETED | 4 Homicide determined buildin | OF INJURY — At horg, atc. (Specify) | | | | | | | own, State) | | | oute Number, |
| COMPLET | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best 2 MEDICAL EXAMINER: On the basis of | | | | | | | | | | | and manner es stated. |
| TO BE C | 296. SIGNATURE AND TITLE OF CERTIFIER Y W | lan FA | > | | | | NSE NUM | BER 260 | | 29d. DAT | E SIGNED | (Marth, Day, Year) |
| F | 30. NAME AND ADDRIES OF PERSON WHO COMPLETED CO | 307 Lau | 1 27) (Type, | Print) | Z | | | | | | | |
| | 31 DATE FILED (MONTH 99 401) July 32 MEGIST | RAR'S CIGNATURE | | | | | | | | | | |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAND | | MENT OF H | | MENTAL HYGIEN REG. NO | E | |
|---------------|--|---|----------------------------------|---|--------------------------------|---|------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) ANTHONY M. | RANDOLPH | JR. | | | 2. DATE OF DEATH MONTH AUGUST 29 | , 1994 YEA | 3. TIME OF DEATH 3:47 a.m. |
| | 4. SOCIAL SECURITY NUMBER 218 - 78 - 8167 | 5. SEX 6. AGE (In yrs | . last birthday) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Dey Year) DE C. 5, 1 | 4.70 | IRTHPLACE (State or Foreign |
| H. | 98. FACILITY NAME (If not institution, give st THE JOHNS HOPKINS | | DF DEATH | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10c. CITY, | BALTIMO | ION | | | 10d. INSIDE CITY V LIMITS? |
| | MARYLAND 100. STREET AND NUMBER | n/a | | BALTIM(| 21213 | | 1994 CITIZENLO | 1 YES 2 NO |
| FUNERAL | 1221 N. | 12. WAS DECEOENT EVER IN U.S. | VENUE | | | IIC ORIGIN? (Specify Ye | ON I I E | ACE — American Indian. |
| B | Never Merried 2 Married 3 Widowed 4 Divorced | FORCES? 1 TYES X IF YES, GIVE WAR OR DATES | ⊠ио | | ecify Cuban, Mexica | n, Puerto Ricen, etc.) | | Black, White, etc. Specify: BLACK |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | | Give kind of we life. Do NOT use | ISUAL OCCUPATION FOR A CONTROL OCCUPATION FOR | DN st of working | 16b. KIND OF BU | | WY . |
| BE CO | 17. FATHER'S NAME (First, Middle, Lest) ANTHONY M. | RANDOLPH SR | • | | 18. MOTHER'S NA CATH | ME (First, Middle, Meiden ERINE W | Sumame) HITE | |
| TO BE | 190. INFORMANT'S NAME (TOPOPTICE) CATHERINE | STINNETTE | 195 MAILING | ADDRESS (Street | nd Number of Parel | AVENUE, | n. BALPT | MORE, MD#13 |
| | 20a METHOD OF DISPOSITION 1A Burlel 2 Cremetton 3 Remote 4 Donation 5 Other (Specify) | ovel from State 20b. PLA | CE AND DATE OF | F DISPOSITION (Na er plate EMO | RIAL G | ARDENS | CATION — CITY O | or Town, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | | | | ID ADDRESS OF FA | CH FH1 | 101 E | . NORTH A |
| TIFICATION | iMMEDIATE CAUSE (Finel disease or condition resulting in deeth) | a. Pue TO (OR AS A CO) | MA THE | Preum | ocystis | | iratory arreat, | Approximata Interval Between Oneet and Death 2 Week |
| CERTIFICATION | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO ON AS A CON | wnod | efrere | | rus Int | ection | 25 Tears |
| : MEDICAL CE | PART II. Other algnificent condition | e contributing to deeth but n | ot recuiting in | the underlying | g ceuse given in | Part I. 24a. WAS AM PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| IAN: | DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL | CONTRIBUTE TO C | AUSE OF | | YES NO | | | |
| HYSICIAN | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | HOSPITAL: 1 Inpetient 2 ER/Outpetien | t 3 🗆 DOA | OTHER: 4 - Nursing Hom | e 5 🗆 Residence | 8 Other (Specify) | | |
| 1 | 1 Netural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME INJU | M 1 1 | YES 2 NO | 28d. DESCRIBE HOW | NJURY OCCURE | D |
| \$0 | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — A building, etc. (Specify) | t home, farm, at | reet, factory, offic | | 28f. LOCATION (Street City or Town, State | end Number or Ru | iral Route Number, |
| COMPLE | onel | CIAN: To the best of my knowledge | | | | | | se(s) and manner on stated. |
| O BE CO | 286. SYGNATURE AND TITLE OF CERTIFIES | usua M | 0 | | L8820 | | | NED (Month, Day, Year) |
| F | Johns Hopkms H | COMPLETED CAUSE OF DEATH | (ITEM 27) (Type, I | lfe S7 | reer 1 | BalTomore | MD | 21205 |
| | 31. DSEPPO (0.6. 1994 | 32. BEGISTHAR'S SUNATUR | | -1-01 | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | | MENT OF H | | MENTAL HYGIEN | | |
|------------------|--|---|----------------------|---------------------------------|---------------------|--|------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| 19 | William | | STA | RR | | September | 3,1994° | 4:20 p M |
| | 4. SOCIAL SECURITY NUMBER | n yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | BIRTHPLACE (State or Foreign | | |
| | 220-05-1410 | 73 YRS. | MONTHS DAYS | 192 | MAryland | | | |
| | Sa. FACILITY NAME (If not Institution, give street | * | | 9b. CITY, TOWN C | OR LOCATION OF DI | EATH | 9c. COUNTY | OF DEATH |
| DIRECTOR | Franklin Squa | a1 | Ro | ssville | 2 | Balti | more County | |
| H H | 10a. STATE 10b. COUNTY | | 10c. CITY | TOWN OR LOCAT | ION | | | 10d. INSIDE CITY |
| | Md. Bal | timore | | | | sedale | | 1 YES 2 X NO |
| RA | | _ | | 101 | . ZIP CODE | | | N OF WHAT COUNTRY? |
| FUNERAL | 4810 Ridge R | Oad 12. WAS DECEDENT EVER IN | 110 40450 | 1 10 1170 000 | | 21237 | | ISA |
| | 1 Never Married 2 X Married | FORCES? 1 YES | 2 NO | If yes, sp | ecify Cuban, Maxica | NIC ORIGIN? (Specify Year, Puerto Rican, etc.) | 8 or No — 14 | , RACE — American Indian, Black, White, etc. |
| B | 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR DA | TES | 1 🗌 YES | 2 NO Specif | У. | | Specify: White |
| | 15. DECEDENT'S EDUCA | TION | 16a. DECEDENT'S I | JSUAL OCCUPATION | ON | 16b. KIND OF BU | ISINESS/INDUS | |
| ᄪ | (Specify only highest grade co | College (1-4 or 5 +) | life. Do NOT use | ork done during mo retired.) | st of working | | | |
| AP. | 11th | | T | ruck D | river | | | |
| COMPLETED | 17, FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Maider | Surname) | |
| H | Harry | Starr | | | <u>M</u> | largaret | Rieme | r |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or Tox | | ' |
| - | Ethel Starr | | | | | Baltimore | MD. | 21237 |
| | 20a, METHOD OF DISPOSITION 1X Burlel 2 Cremation 3 Remove | al from State cemi | PLACE AND DATE O | ner plece) | | | OCATION — City | y or Town, State |
| | 4 Donetion 5 Other (Specify) | Bi | altimor | | | | Baltim | ore Md. |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | ISEE | 11 | | D ADDRESS OF FA | uneral HO | me of | Essex |
| | 1. Tury | Conne | lu | 300 | Mace Av | re. Balti | more | MD. 21221 |
| | 23. PART I. Enter the diseases, or cor ahock, or heart failure. Lis | mplications that caused | the death. Oo n | ot anter tha mo | de of dying, suc | h ss cardiac or resp | iratory arrest | t, Approximate |
| | IMMEDIATE CAUSE (Final | n only only out of the | | | | | | interval Between Onset and Death |
| | disease or condition resulting in death) | Hemorrhage | | | | | | 2 hours |
| 7 | | | CONSEQUENCE OF | • | | | | |
| N N | Sequentially list conditions, | Ruptured Abd | | | neurysm | | | |
| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | CONSEQUENCE OF |): | | | | |
| FIC | CAUSE (Disease or Injury that Initiated events | DUE TO (OR AS A | CONSEQUENCE OF |): | | | | |
| E | resulting in death) LAST | | | ,- | | | | j |
| 빙 | d. | | | | | | | |
| Ä | PART II. Other significant conditions | contributing to death be | ut not reaulting is | tha underlying | g causa given in | | AUTOPSY RMED? | 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO |
| ă | | | | | | 1 YES | NO NO | COMPLETION OF CAUSE OF DEATH? |
| M | | | | | | | | 1 TYES 2 NO |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRI | | | | UNCERTAI | N 🗆 📗 | | |
| 2 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | OSPITAL: | 28. PLACE OF DEAT | OTHER: | | | | |
| IYS | 1 X YES 2 NO 1 | X Inpatient 2 ☐ ER/Outpo | etlant 3 DOA | 4 - Nursing Hom | | 8 Other (Specify) | | |
| | 1 Netural 5 Pending | (Month, Day, Year) | 28b. TIME INJU | JRY WO | RK? | 28d. DESCRIBE HOW | INJURY OCCUR | ED |
| B | 2 Accident Investigation | 20. BLACE OF BURIDA | A1 h | | ES 2 NO | | | |
| | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Speci | — At nome, term, st | reet, tectory, office | | 281. LOCATION (Street City or Town, State | and Number or i | Rural Route Number, |
| COMPLETED | 29e. CERTIFIER | | | | | | | |
| MP | (Check only | | | | | | | THE THE RESERVE TO SHOW IN |
| 8 | | On the basis of examination | and/or investigation | i, in my opinion, d | esth occured at the | time, data and place, e | nd dua to the c | ause(a) and manner as stated. |
| H | 296, SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUI | WBER | 29d. DATE S | IGNED (Month, Day, Year) |
| <u>6</u> | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF THE | TH STEM OF T | 9-7-11 | NIF | 1 | 1 7/3 | 5/97. |
| | | | | | Polto M | 3 21227 | • | - |
| | Sherwood Leo MD. | 32. REGISTRAR'S SIGNA | TURE | C DI. | Dailo, M | d. 21237 | | |
| | 31. DAYSEP 0116 1994 | This Danies - R | while | | | | | |

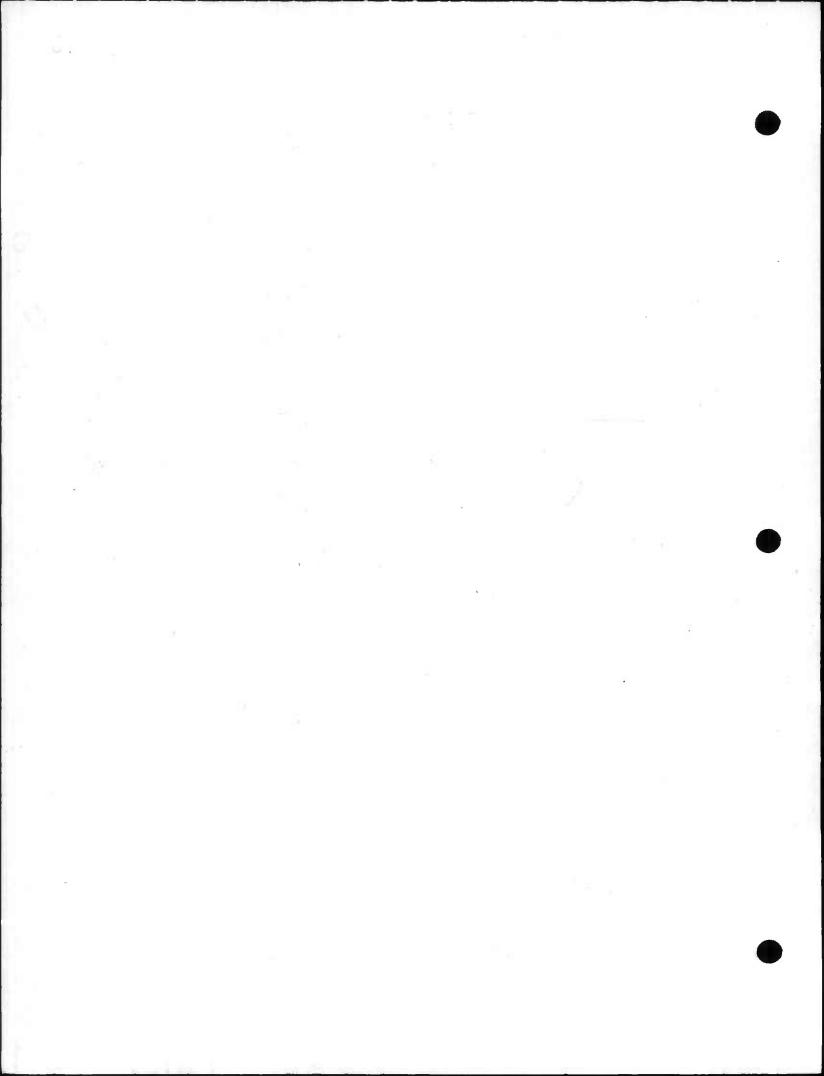
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | the instantaneous system of the standard programmer of the standard program | narked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|--|---|
| 100 | 3 5 | |

| | 1 - FOR STATE OF MARYLAND C | | T OF HEALTH AND I | MENTAL HYGIEN | | |
|-----------------------|--|--|--|--|----------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) Paul Vincent Sn | | | 2. DATE OF DEATH MONTH DA | NY YEAR | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. II) $212-03-8249$ 1 $2 m 2 property 80$ | YRS. SF UNDE | R 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Aug 20, 1 | 914 8. BIF | THPLACE (State or Foreign Intry) Maryland |
| TOR | 99. FACILITY NAME (If not Institution, give street and number) Good Samaritan Hospital RESIDENCE OF DECEDENT | 9b. CIT | Baltimore | | 9c. COUNTY OF | FDEATH |
| DIRECTOR | Maryland 10b. COUNTY | OR LOCATION Baltimore | City | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | | |
| FUNERAL | 106. STREET AND NUMBER 2414 Kentucky Avenu | е | 101. ZIP CODE | 1213 | | d States |
| ВУ | 11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 X IF YES, GIVE WAR OR DATES | | WAS DECENDENT OF HISPAN If yes, specify Cuben, Mexice 1 YES 2 NO Specify | n, Puerto Rican, etc.) | Bi | ACE — American Indian, ack, White, etc. Pecify: White |
| COMPLETED | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | DECEDENT'S USUAL C Give kind of work done fe. Do NOT use retired.) ISUYANCE | during most of working | 16b. KIND OF BUS | SINESS/INDUSTRY | , |
| BE CON | Joseph H. Sneeringer | | Mary | ME (First, Middle, Meiden / Welsh | | |
| 10 | M. Charlett Sneeringer | 2414 | s (Street and Number or Rural F Kentucky Aver | nue Baltir | more, Mo | d. 21213 |
| | 1 Suriel 2 Cremation 3 Removal from State carnellary, or DUI a | remetory or other place NEY Valle | y Memorial 9 | /8/94 Tim | CATION — City or IONIUM | Maryland |
| | Multon Knight - | ht Jr " 5 | 305 Harford | Rd. Balti | dJ. Ruc more,Md | k, Inc. |
| | 23. PART i. Enter the diseases or complications that caused the disease, or haart failure. List only one cause on each lin iMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSI | EOUENCE OF): | IOCK | h as cardiac or respi | ratory arrest, | Approximate Interval Between Onset and Death 3 hours |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | EOUENCE OF): | FARCTION | | | - 48 hours |
| PHYSICIAN: MEDICAL CE | PART II. Other aignificant conditions contributing to death but not PERIPHERAL AIZT | resulting in the u | nderlying cause given in | | MED? | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | OTHE | | | | |
| ВУ РНҮ | 27. MANNER OF DEATH 1 | 28b. TIME OF INJURY | rsing Home 5 Residence 28c, INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW II | NJURY OCCURED | |
| | 3 Suicide 8 Could not be 4 Homicide determined 28e. PLACE OF INJURY — At h building, etc. (Specify) | nome, farm, street, fac | ctory, office | 281. LOCATION (Street e City or Town, Stete) | and Number or Run | al Route Number, |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, of my knowledge, of my knowledge, of my knowledge, of my knowledge, of my knowledge, of my knowledge, or my | | | | | e(e) end menner ee stated, |
| TO BE (| 296. SIGNATURE AND THE OF CERTIFIER | | 29c. LICENSE NUN P- 0 7 | | PSE | PT. 3RD 1494 |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (IT | PARITANT | USPITAL SGOI | LOCHRAVEN | BALTI | MOR E |
| | SEP 06 1994 32. REGISTERRY SIGNATURE SEP 06 1994 | Rordall | | | | |



ges 1, 2, 3 should

DIRECTOR

FUNERAL

BY

COMPLETED

BE

2

CERTIFICATION

PHYSICIAN: MEDICAL

ВҮ

COMPLETED

BE

2

If any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Diseese or injury

1 - YES 2 - NO

27. MANNER OF DEATN

4 Nomicide

1 -

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760, FI REPAL DIRECTOR: After this certificate has been signed by the attending thin 72 hours after death with the State Dept. of Health and Mental Hygie TANT: If Item 28 Is marked, or item 23 shows any Injury, or off OR ATTENDING PHYSICIAN: The law requires that the death cert

| | 9 | | |
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| | t permit. | | |
| physician. | anding physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pa | | |
| Tending | as the | | |
| or at | use | | |
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| If definitions be executed within the course after dealth. Page of may be retained by the hospital of attending physical definitions and physical descriptions. | funeral (| | or other traumatic event, the medical examiner must be notified at once. |
| dilei c | by the | Hygiene prior to burial, cremation, or removal. | ical e |
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| FOR STATE REGISTRAR | | STATE OF N | MARYL | | | | | IEALTH DEAT | | MENTAL HYGIEN | _ | | |
| 1. DECEDENT'S NAME (First, | Middle, Last) | | | | | | | | | 2. DATE OF DEATH | | | 3. TIME OF DEATN |
| SHIRL | EY L | EWIS S | TROT | HER | | | | | | 9-2-94 | W | YEAR | 10:00P M |
| 4. SOCIAL SECURITY NUMBI | ER | 5. SEX | 6. AGE | (In yrs. last | birthday) | IF UNDER | | IF UNDER | | 7. DATE OF BIRTH | | 8. BIRTH | IPLACE (State or Foreign |
| 214-40-4315 | | 1 □ M 2 🂢 F | 77 | | YRS. | MONTHS | DAY\$ | HOURS | MIN. | (Month, Day, Year) 8-1-17 | | Count V T | RGINIA |
| 9a. FACILITY NAME (If not ins | stitution, give st | treet and number) | | | | 9b. CITY, | TOWN (| OR LOCATIO | ON OF DE | ATN | 9c. COU | NTY OF D | |
| 3110 PRESE | BURY S | T. | | | | | BA | LTIM | ORE | | В | ALTI | MORE |
| RESIDENCE OF DEC | EDENT 10b. COUNTY | | | | | | | | | | | | TIOTE |
| MD. | | | | | 10c. CIT | Y, TOWN O | | | | | | | 10d, INSIDE CITY LIMITS? |
| | BAL | TIMORE C | • | | | BAL | | | | | | | 1X YES 2 □ NO |
| 10e. STREET AND NUMBER | NDI TOX : | 0.77 | | | | | 101 | r. ZIP CODE | | | 10g. CIT | IZEN OF V | VHAT COUNTRY? |
| 3110 PRES | SBURY | ST. | | | | | | | | 21216 | | U.S | .A. |
| 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO IF YES, GIVE WAR OR DATES | | | | MED O | If yes, specify Cuban, Mexican, Puerlo Rican, etc.) 1 YES 2 N NO Specify: Specify: | | | | | E — American Indian, k, Whita, atc. lly: BLACK | | | |
| | DENT'S EDUC | | | 16a. DEC | EDENT'S | USUAL OC | CUPATIO | ON pet of working | | 16b. KIND OF BUS | INESS/IN | DUSTRY | DLEICH |
| Elementary/Secondary (0- | | College (1-4 or 5 + | -) | life. | (Give kind of work done during most of working life. Do NOT use retired.) SCHOOL TEACHER BALTIMORE. | | | RE C | ITY SCH. SYS | | | | |
| 17. FATNER'S NAME (First, Mic | ddle, Last) | | | | | | | 18. MOTN | ER'S NA | ME (First, Middle, Malden | | | |
| JAMES L. I | EWIS | | | | | | | ١ ١ | የልጥጥ | TE ELLISO | NT | | |
| 19a. INFORMANT'S NAME (Ty | pe/Print) | | | 19b | MAILING | ADDRESS | (Street a | | | Route Number, City or Town | | p Code) | |
| HAYWARD ST | ROTHE | R | | | | | | | | T. MD. 212 | | | |
| 20a:/METNOD OF DISPOSITIO | n 3 🗆 Ramo (Specify) | | cen A | PLACEA | ND DATE (| of disposi | TION (Na | ame of | | DATE 20c. LO | CATION - | City or To | |
| 21. SIGNATURE OF FUNERAL | SERVICE LIC | CON MAN | | | | 22. N N 2 | UTT 501 | ER FU | JNER JNS | CHUTY | | | . MD. 21216 |
| V | ert fsilure. I | ompilestions that List only one csu | ceused se on e | the des | sth. Do r | Dt enter | the mo | de of dyle | ng, aucl | n aa cerdiec or reapi | ratory ar | rest, | Approximate interval Between |
| immediate cause (Fine disease or condition resulting in desth) | •i → , | e | | | | | ard | iova | scu | lar Dise | ase | | Onset and Death |
| | | DUE TO | (OR AS A | CONSEO | UENCE O | 7: | | | | | | | |
| Sequentially list condition | ona, | b. Due to | (OB AC 4 | CONSEC | HENCE OF | | _ | | | | | | |

thet initieted events reauiting in deeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i.

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 TO NO OF DEATH? INOUIRY 1 YES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 25. WAS CASE REFERRED TO MEDICAL

28. PLACE OF DEATN (Check only one)

HOSPITAL: OTHER: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. DESCRIBE NOW INJURY OCCURED

28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 1 Natural 5 Pending Investigation M 2 Accident 3 Sulcide S Could not be determined

28c. INJURY AT WORK? 28e. PLACE OF INJURY — Al home, farm, street, factory, office building, atc. (Specify)

1 YES 2 ND 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER 1 🗌 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 💢 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

Wonald. nigho MD 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE DF DEATN (ITEM 27) (Type, Print)

O.C.M.E.

SEPT.06,1994 111 Penn Street, Baltimore, Maryland 21201

31. DAT SEP WO' 6 1994

Donald G. Wright M.D.

32. REGISTRAR'S SIGNATURE ilis Dendem-Rudall

PITAL

| | 1. DECEDENT'S NAME (First, Middle, La | est) | CERTIFICA | TE OF DEATH | 2. DATE OF | REG. NO. | 1 | 3 TIME OF DEA |
|--------------------------------------|--|--|--|---|---|--|---|---|
| | CLARENCE | ELEXIOS | SHU | TE , JR. | CHONTH | | 94AR 0 | 3. TIME OF DEA 07:50 A |
| | 4. SOCIAL SECURITY NUMBER 065–07–0958 | 5. SEX 6. AGE | (In yrs. last birthday) IF U | NDER 1 YEAR IF UNDER 24 HRS THS DAYS HOURS MIN. | (Month, Di | | Country) | W YOR |
| OR | So. FACILITY NAME (If not institution, git NORTH ARUNDEL I | | | GLEN BURNIE | | 9c. COU | NTY OF DEA | |
| RECTOR | RESIDENCE OF DECEDENT 10e, STATE 10b, COU | | 10c. CITY, TO | WN OR LOCATION | | | | 10d. INSIDE CIT |
| L DIR | MARYLAND 100. STREET AND NUMBER | ANNE ARUND | EL | GLEN BURNI | E | | | LIMITS? |
| FUNERAL | CENTER, 7355 F | URNACEO BRAK | RSING & R | EHA B 21060 |) | | J.S.A | AAT COUNTRY? |
| ВУ | 11. MARITAL STATUS 1 Never Married 2 X Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YES | 2 NO | 13. WAS DECENDENT OF HISE It yes, specify Cuben, Mex 1 YES 2 NO Spe | Icen, Puerto Rice | | 14. RACE - Black, Specify: | - American ind White, etc. |
| TED | 15. DECEDENT'S E (Specify only highest gr | | 16a. DECEDENT'S USUA (Give kind of work of | lone during most of working | 16b. KII | ND OF BUSINESS/INC | DUSTRY | |
| COMPLET | Elementary/Secondary (0-12) UNKNOWN | College (1-4 or 5+) UNKNOWN | STEAMF | | | LOCAL 4 | 38 | |
| | 17. FATNER'S NAME (First, Middle, Last) CLARENCE E. S | | • | | | ile, Meiden Surname) N TURNE | R | |
| TO BE | 190. INFORMANT'S NAME (Type/Print) MR. JOHN A. I | | | RESS (Street and Number or Rur | | | | I BURN |
| | 200. METHOO OF DISPOSITION | 20 | b. PLACE AND DATE OF DIS | SPOSITION (Name of 9 / | 9/94ATE | 20c. LOCATION — | | MD.2 |
| | 1 M Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) | | GLEN HAVE | N MEMORIAL | PK | GLEN 1 | | |
| | 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE | 11- | 22. NAME AND ADDRESS OF | VENUE | NGLETON | FUNI | ERAL I |
| | 23. PART I. Enter the diseases, | or complications that cause | ed the death. Do not a | GLEN BURNI | F. MA | RVI. AND | 21061 | Approxir |
| | shock, or heart fallu iMMEDIATE CAUSE (Final disease or condition resulting in death) | re. List only one cause on a | each line. | entravapal | | 0 15 | | Onset ar |
| | | DUE TO (OR AS | | | | | | |
| | | 5000 | A CONSEQUENCE OF): | | | 0 | | |
| NOL | Sequentially list conditions, if any, leading to immediate | - Seaso | A CONSEQUENCE OF): | | | 0 | | |
| FICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | b. Se SS 6 OUE TOVOR AS C. Preum | .6 | | | 0 | | |
| ERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING | b. Se SS 6 OUE TOVOR AS C. Preum | A CONSEQUENCE OF): | | | 0 | | |
| AL CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted eventa resulting in deeth) LAST | b. OUE TO OR AS c. Pulling due to (or as d. | A CONSEQUENCE OF): | | | ia. WAS AN AUTOPSY | 24b. V | WERE AUTOPS Y |
| 0 | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted eventa resulting in deeth) LAST | b. OUE TO OR AS c. Puller TO (OR AS d. Liona contributing to death | A CONSEQUENCE OF): | | In Part I. 24 | | 24b. V | AMILABLE PRIOR |
| MEDICAL C | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that intileted eventa resulting in death) LAST PART II. Other significent conditions and the conditions are significent conditions. | b. OUE TO OR AS c. Puller TO (OR AS d. Liona contributing to death | A CONSEQUENCE OF): | | In Part I. 24 | ia. WAS AN AUTOPSY PERFORMED? | 24b. V | MAILABLE PRIOR COMPLETION OF OF DEATH? |
| MEDICAL C | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other significent conditions to the condition of the condi | oue to or as c. Philm oue to (or as d. tions contributing to death | A CONSEQUENCE OF): A CONSEQUENCE OF): but not resulting in the | e underlying cause given | in Part I. 24 | ia. WAS AN AUTOPSY PERFORMED? | 24b. V | AVAILABLE PRIOF |
| SICIAN: MEDICAL C | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted eventa resulting in deeth) LAST PART II. Other significent conditions to the conditions of the cause of th | b. OUE TO OR AS c. Plum DUE TO (OR AS d. tiona contributing to death HOSPITAL: 1 Ill Inputent 2 = ER/Out | A CONSEQUENCE OF): A CONSEQUENCE OF): but not resulting in the operation of the consequence of the consequ | 28. PLACE OF OEATH (Nursing Nome 5 Residence | in Part I. 24 | ia. WAS AN AUTOPSY PERFORMED? YES 2 NO | 24b. V | MAILABLE PRIOR COMPLETION OF OF DEATH? |
| PHYSICIAN: MEDICAL C | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other significent conditions to the condition of the condi | b. OUE TO OR AS c. Prilim DUE TO (OR AS d. Liona contributing to death HOSPITAL: 1 Linguister 2 ER/Out 286. OATE OF INJURY (Month, Day, Yeer) | A CONSEQUENCE OF): A CONSEQUENCE OF): but not resulting in the operation of the consequence of the consequ | 28, PLACE OF OEATH (HER: Nursing Nome 5 Residence 28c. INJURY AT WORK? M 1 YES 2 NO | in Part I. 24 | ia. Was an autopsy performed? Yes 2 No | 24b. V | MAILABLE PRIOR COMPLETION OF OF DEATH? |
| BY PHYSICIAN: MEDICAL C | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted eventa resulting in deeth) LAST PART II. Other significent conditions of the condition of the condi | b. OUE TO OR AS c. Place of INJURY (Month, Day, Yeer) 28e. PLACE OF INJURY be be | A CONSEQUENCE OF): A CONSEQUENCE OF): but not resulting in the partial of the p | 28, PLACE OF OEATH (HER: Nursing Nome 5 Residence 28c. INJURY AT WORK? M 1 YES 2 NO | in Part I. 24 1 (Check only one) 28 G Other (S 28d, DESCR | ia. Was an autopsy performed? Yes 2 No | 24b. V | MAILABLE PRIOF COMPLETION OF OF DEATH? 1 YES 2 |
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3. TIME OF DEATH

10d. INSIDE CITY

1 YES 2 X NO

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8. BIRTHPLACE (State or Foreign

Washington

9c. COUNTY OF DEATH

Baltimore

10g. CITIZEN OF WHAT COUNTRY?

United States

Specify:

14. RACE — American Indian, Black, White, atc.

12:03 am

BALTIMORE, MARYLAND 21215-0020

FOR

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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2. DATE OF DEATH HELEN Ε THOMPSON Sep 3 1984 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH April. 216-05-8051 MONTHS DAYS HOURS 1 M 2 X F 81 YRS. detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY TOWN OR LOCATION OF DEATH Saint Joseph Hospital DIRECTOR Towson, Maryland RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland **Baltimore** Timonium FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 5 Turnberry Court 21093 ours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 K NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yas or No—
If yes, specify Cuban, Maxican, Puerto Rican, etc.)
1 YES 2 NO Specify: 11. MARITAL STATUS 1 Never Merried 2 Merried ВY 3 X Widowed 4 Divorced 15. DECEDENT'S EDUCATION COMPLETED 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade compi Elementary/Secondary (0-12) College (1-4 or 5 +) 12 Homemaker Own Home once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surneme Isaac Elias <u>Johannssen</u> Gunhilde BE page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Wendy J. Thompson Turnberry Court Timonium, MD 21093 Pe 20e. METHOD OF DISPOSITION
1 Service Buriel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION / Name of 20c. LOCATION - City or Town, State DATE must funeral director, Dulaney Valley Memorial Gardens Donation 5 Other (Specify) 9/7/94 Timonium, examiner 21. SIGNATURE OF FUNERAL REPVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Mitchell- Wiedefeld Home, Inc. John G. Reitz 6500 York Road Baltimore, the in by the medical 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. This only one cause on each line. ö pelli IMMEDIATE CAUSE (Final Mental Hygiene prior to burnal, cremation, the executed with disease or condition **CEREBROVASCULAR ACCIDENT INVOLVING** attending physician and completely resulting in dasth) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): LEFT MIDDLE CEREBRAL ARTERY CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, lasding to immediate cause. Enter UNDERLYING death certificate be other CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated aventa resulting in death) LAST 0 Injury, signed by the a Health and Mem PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? requires that the MEDICAL shows any PREVIOUS C.V.A. of Health 1 TES NO LEFT VENTRICULAR ANEURYSM peen PHYSICIAN: AMP. Dept 23 has 25. WAS CASE REFERRED TO MEDICAL The 28. PLACE OF DEATH (Check only one) Item EXAMINER? HOSPITAL: State this certificate HOSPITAL OR ATTENDING PHYSICIAN: Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 0 the 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28e. DATE OF INJURY marked, 28d. DESCRIBE HOW INJURY OCCURED with 5 Pending 1 YES 2 NO 84 After death Accident Investigation 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) after de 28 Is 8 Could not be determined COMPLETED DIRECTOR: 4 Homicide 29a. CERTIFIER
(Check only one)

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. hours Item TO THE FUNERAL D
be filed within 72 ho
IMPORTANT: If IN THE HOSPITAL (
THE FUNERAL D
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES NO 281. LOCATION (Street and Number or Rural Route Number, City or Trum, State) 2
MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, end due to the cause(s) end manner as stated. 29d. DATE SIGNED (Month, Day, Year) 09. 03-DHMH-16 Rev 1/89

29c. LICENSE NUMBER

D41410

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29b. SIGNATURE AND TITLE OF CERTIFIER

SEP 0 6 1994

min

30. NAME AND ADDITION SO PLUSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print,

JOGINDER F. MEHTA M.D. ST. JOSEPH HOSPITAL TOWSON, M.D.

32. REGISTRAR'S SIGNATURE

Market and a second of

3. TIME OF OEATH

21215

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DHMH-18 Rev 1/89

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2. DATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First Middle Last

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4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 1 M 2 60 5706 215 49 YRS. NOV 17. 1944 MARYLAND use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH Sc. COUNTY OF DEATH DIRECTOR SINAI HOSPITAL BALTIMORE RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10b. COUNTY IOd. INSIDE CITY MARYLAND BALTIMORE YES 2 NO FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4132 SUNNYSIDE AVENUE 21215 U.S. OF A. retained by the hospital or attending physician. 5 should be detached for use as the burial-tran 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yee, specify Cuban, Mexicen, Puerto Ricen, etc.)
 U YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried
3 Divorced BY BLACK COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high ntary/Secondary (0-12) College (1-4 or 5+) 12th SECRETARY RAINCOAT MFG. CO. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) GEORGE HILL F HATTIE LEE GILES BE notified 19e. INFORMANT'S NAME (Type/Print) 2 page 5 s MR. CHRISTOPHER TITTLE 4132 SUNNYSIDE AVENUE BALTIMORE, MD. after death. Page 6 may be pe 20e. METHOD OF DISPOSITION

1 Burtel 2 Cremetion 3 Re
4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must funeral director, ARBUTUS MEM. PARK 9/7/94 BALTIMORE, MARYLAND 21. SIGNATURE OF PURPLAL SERVICE LICENSOF LEWIS T. GWYNN examiner 22. NAME AND ADDRESS OF FACILITY LEWIS T. GWYNN FUNERAL HOME ewis 4517 PARK HEIGHTS AVE. BALTO. n by the fremoval. medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cardiec or respiratory arrest, Approximate ahock, or heart fallure. List only one cause on each line filled in interval Between 0 **IMMEDIATE CAUSE (Final** Onset and Death cremation. the disease or condition resulting in death) alo event. to bunal. СОП traumatic CERTIFICATION 1 Sequentisily list conditions, If any, leading to immediate attending physician prior cause. Enter UNDERLYING andia CAUSE (Disease or injury other Hygiene that initiated events resulting in death) LAST 0 Mental the PART ii. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE WAS AN AUTOPSY PERFORMEQ? MEDICAL Signed by the any 1 - YES 2 NO OF DEATH? Shows 1 TES 2 KNO been o DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) PHYSICIAN: 23 certificate has 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Неш State **EXAMINER?** 1 DE YES 2 NO OTHER: Inpatient 2 - ER/Outpatient 3 - DOA 0 the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) with a 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, INJURY 1 Natural 5 Pending Investigation м 1 YES 2 NO BY After Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 COMPLETED 8 Could not be DIRECTOR: hours after 4 Homicide 28 Hem 29e. CERTIFIER CERTIFYING PHYSICIAN: To the beet of my kno dge, death occurred at the time, date end place, end due to the cause(e) and menner as stated. FUNERAL (HOSPITAL = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: P 2 MEDICAL EXAMINER: On th vestigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end manner es stated 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 45 0 gle 9 ESS OF PERSON WHO COMPLETED CAUSE OF OPATH (ITEM 27) (Type, Print) TAMIES ONGER SINAI BALTIM 1-105P. 31. DATE FILEO (Month, Day, Year) 12 REDISTRAR'S SIGNATURE SEP 0 6 1994

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

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| 020 | physician. | burial-transit permit. Pag |
| BALTIMORE, MARYLAND 21215-0020 | Hours after death. Page 6 may be retained by the hospital or attending physician | etely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should |
| BALTIMORE, N | ifter death. Page 6 may be r | the funeral director, page 5 |
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

|) The transport of ATTENDING PHYSICIAN: The law requires that the death certificate be executed within shours after death. Page 6 may be retained by the hospital or attendi | TO HE PANCHAL UPECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as it | be the written 22, ours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral. | IMPORTMENT from 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| uires that the dea | signed by the atl | Health and Mentz | ws any injury, |
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| ATTENDING PHYSIC | CTOR: After this ce | s after death with t | 1 28 is marked, |
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| | | STATE OF MARYLAND / [| | | ENTAL HYGIENE | | |
| _ | REGISTRAR | CEI | RTIFICATE OF | DEATH | REG. NO. | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 3 | DATE OF DEATH DAY | YEAR | 3. TIME OF DEATH |
| | Francette | T | unstall | | August 2 | 7 19 | 0/, 11.00 . |
| | | SEX 6. AGE (In yes, lest 0 | | IF UNDER 24 HRS. 7 | DATE OF BIRTH | The second named in column 2 is not a second | THPLACE (Stage or Foreign |
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| | Se. FACILITY NAME (If not institution, give street | and numbers a l | No. CITY TOWN | OR LOCATION OF DEA | - 4 | BE COUNTY OF | MANAN I |
| Œ | Manuelana 1. | en holaron | 90 | 3-17 | | AE 000H11 01 | 7" |
| 5 | RESIDENCE OF DECEMENT | 71/1405V) | - 4 | AHIMORE | 5_ | | 1-11 |
| E | 10s. STATE 10s. COUNTY | / | 10c. CITY, TOWN OR LOC | ATION | | | 10d. INSIDE CITY |
| ривестоя | MD | | 95017 | MARKE | | | LIMITS? |
| | 104 STREET AND HUMBER | | - CATA | or, ZIP CODE | | Mrs. CYTIZEN OF | F WHAT COUNTRY? |
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| FUNERAL | 1 GU MYGYAD | - HB | | 441 | | (1) | 7)17 |
| 5 | 1f. MARITAL STATUS 12 | FORCES? 1 YES 2 NO | | CENDENT OF HISPANIC specify Cuban, Maxican, I | | | ACE — American Indian, lack, White, etc. 2 |
| ВУ | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DATES | 1 🗆 🕶 | 5 2 NO Specify: | | 452 | STON |
| | 15. DECEDENT'S EDUCAT | nu I u need | | | The same as a second | 17 | 1444 |
| = | (Specify only highest grade con | quieted) (Give | EDENT'S USUAL OCCUPAT thind of work done during it | | 16b. KIND OF BUSI | MESS/INDUSTRY | |
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| COMPLETED | 9/// | | V/1 / 12-17 / 14/ | Dt- | | | |
| 8 | 17. PATHOPI'S NAME (First, Microlin, Last) | | | 18. MOTHER'S NAME | (First, Mickelle, Mardon S | urgany) | ^ |
| BE | CHARLES /ALL | <i>by</i> | | 11/1/17 | REDINII | 11/1/1/1/2 | 9 |
| 0 | 190. INFORMANT'S NAME (Types Prost) | 411 100. | MAILING ADDRESS (Street | and Mumber or Puril Plan | AN NESTON City of Xours. | State Zip Code) | 71 |
| - | I HEREGA OM | 117 1 | 200271 | NIMARD | CARCIE | POPTERA | 11, 30013 |
| | 20 METHOD OF DISPOSITION 1 Burial 2 Creptation 3 - Remova | 20b. PLACE AN | DATE OF DISPOSITION | Name of | DATE / 209 LOC | ATION -City or | Town, State |
| | 4 □ Donation 5 □ Other (Specify) | from State cameter from | 7; ZDDA | 9/2 | 194 LAR | 971111 | VE MD. |
| | 21. SIGNATURE OF SCHERAL SERVICE LICEN | set//// | 22. y/9×E | AND ADDRESS OF THE | HOUND IN | EDA/ | Nouse Va. |
| | 1 4 N Y | 1.1 | GA | 11/1/14 | The full | JERKE AND | 4010/0-111/2 |
| | V HUM / I. // | man de | | | | | |
| | | 414 | | 170 h | PODHILA | on In | NGS 4229 |
| | 23. PART I. Finter the diseases, or con aback, or heart fallure. Lia | plications that caused the deat | th. Do not antar tha m | ode of dying, such | as cardiac or reapin | etory arreat, | Approximate Interval Retween |
| | immediate cause (Final | pplications that caused the deat t only one cause on each line. | th. Do not antar tha m | ode of dying, such | as cardiac or reapin | etory arreat, | Approximate interval Between Onset and Death |
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| Z | iMMEDIATE CAUSE (Final disease or condition | Cardi OVas ca | ular Even | | as cardisc or reapin | etory arreat, | Interval Between Onset and Death 40 min. |
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| S | IMMEDIATE CAUSE (Finai disease or condition resulting in daeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in death) LAST | Cardiovas crouse on each line. Cardiovas crous to (or as a consecution of consec | ular Even athy JENCE OF): | t | irt I. 24s. Was an a Perfora | AUTOPSY 2 | Interval Between Onset and Death 40 min. 2 years 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE |
| S | IMMEDIATE CAUSE (Finai disease or condition resulting in daeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in death) LAST | Cardiovas crouse on each line. Cardiovas crous to (or as a consecution of consec | ular Even athy JENCE OF): | t | irt I. 240. Was an A | AUTOPSY 2 | Interval Between Onset and Death 40 min. 2 years 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? |
| MEDICAL CE | IMMEDIATE CAUSE (Finai disease or condition resulting in daeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in death) LAST PART II. Other aignificant conditions of | Cardiovas cause on each line. Cardiovas cause on each line. Cardiovas cause on consecution of the consecut | ular Even athy JENCE OF): JENCE OF): auiting in the underlyi | t ng cause givan in Pa | irt I. 24s. Was an a Perfora | AUTOPSY 2 | Interval Between Onset and Death 40 min. 2 years 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDICAL CE | IMMEDIATE CAUSE (Finai disease or condition resulting in daeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in death) LAST | Cardiovas cause on each line. Cardiovas cause on each line. Cardiovas cause on consecution of the consecut | ular Even athy JENCE OF): Building in the underlyie | ng cause givan in Pa | ort i. 24s. WAS AN A PERFORM 1 YES 2 | AUTOPSY 2 | Interval Between Onset and Death 40 min. 2 years 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? |
| MEDICAL CE | immediate cause (Finai disease or condition resulting in dasth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in death) LAST PART II. Other aignificant conditions of the conditions of th | Cardiovas cause on each line. Cardiovas cause on each line. Cardiovas cause on each line. Cardiovas cause on cardiomy op a consecue of the consecue on the consecue on the cardiovas cause of the cardiovas | ular Even athy JENCE OF): JENCE OF): auiting in the underlyi E OF DEATH 26. | TYES NO | art i. 24a. WAS AN A PERFORM 1 UYES 2 | AUTOPSY 2 | Interval Between Onset and Death 40 min. 2 years 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? |
| MEDICAL CE | IMMEDIATE CAUSE (Final disease or condition resulting in daeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in daeth) LAST PART II. Other aignificant conditions of the conditions of th | Cardiovas cause on each line. Cardiovas cause on each line. Cardiovas cause on each line. Cardiovas cause on cardiomy op a consecut one to (or as a consecut on tributing to death but not reconstruction on the cardiovas cause on the cardiovas cause on the cardiovas cause on the cardiovas cause on the cardiovas cause of the cardiovas cause o | Ular Even athy JENCE OF): JENCE OF): auiting in the underlyi E OF DEATH 26. OTHER: DOA 4 Nursing Ho | TYES NO PLACE OF OEATH (Check | 24a. WAS AN A PERFORM 1 VES 2 | AUTOPSY 2 AED? X NO | Interval Between Onset and Death 40 min. 2 years 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? 1 YES 2 NO |
| PHYSICIAN: MEDICAL CE | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in death) LAST PART II. Other aignificant conditions of the conditions of th | Cardiovas cause on each line. Cardiovas cause on each line. Cardiovas cause on each line. Cardiovas cause on cardiomy op a consecut one to (or as a consecut on tributing to death but not reconstruction on the cardiovas cause on the cardiovas cause on the cardiovas cause on the cardiovas cause on the cardiovas cause of the cardiovas cause o | Ular Even athy JENCE OF): BUILDING OF): BUILDING OF DEATH 26. OTHER: DOA 4 Nursing Ho INJURY 28b. IIME OF INJURY 28c. II | YES NO PLACE OF OEATH (Check | art i. 24a. WAS AN A PERFORM 1 UYES 2 | AUTOPSY 2 AED? X NO | Interval Between Onset and Death 40 min. 2 years 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? 1 YES 2 NO |
| PHYSICIAN: MEDICAL CE | IMMEDIATE CAUSE (Final disease or condition resulting in daeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in daeth) LAST PART II. Other aignificant conditions of the conditions of th | Cardiovas cause on each line. Cardiovas cause on each line. Cardiovas cause on each line. Cardiovas cause on consecution of the consecution of the consecution of the cause | Ular Even athy JENCE OF): BUILDING OF DEATH 26. DOA OTHER: DOA 4 Nursing Ho 1 Nursing Ho 1 Nursing Ho 28b. IIME OF NUTSING HO 1 NUTS | YES NO PLACE OF OEATH (Check ome 5 Residence 6 RUURY AT ORK? YES 2 NO | 24a. WAS AN A PERFORM 1 VES 2 | AUTOPSY 2 AED? X NO | Interval Between Onset and Death 40 min. 2 years 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? 1 YES 2 NO |
| D BY PHYSICIAN: MEDICAL CE | IMMEDIATE CAUSE (Finai disease or condition resulting in daeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in death) LAST DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 10 Neturel | Cardiovas cause on each line. | Ular Even athy JENCE OF): BUILDING OF DEATH 26. DOA OTHER: DOA 4 Nursing Ho 1 Nursing Ho 1 Nursing Ho 28b. IIME OF NUTSING HO 1 NUTS | YES NO PLACE OF OEATH (Check ome 5 Residence 6 RUURY AT ORK? YES 2 NO | 24a. WAS AN A PERFORM 1 VES 2 | JURY OCCUREO | Interval Between Onset and Death 40 min. 2 years 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF OCATH? 1 YES 2 NO |
| ED BY PHYSICIAN: MEDICAL CE | IMMEDIATE CAUSE (Finai disease or condition resulting in daeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in death) LAST PART II. Other aignificant conditions of the conditions of the cause o | Cardiovas crouse on each line. Cardiovas crouse out to (or as a consecut out to (or as a consec | Ular Even athy JENCE OF): BUILDING OF DEATH 26. DOA OTHER: DOA 4 Nursing Ho 1 Nursing Ho 1 Nursing Ho 28b. IIME OF NUTSING HO 1 NUTS | YES NO PLACE OF OEATH (Check ome 5 Residence 6 RUURY AT ORK? YES 2 NO | art i. 24a. WAS AN A PERFORM 1 VES 2 3 conly one) Other (Specify) 8d. OESCRIBE HOW IN | JURY OCCUREO | Interval Between Onset and Death 40 min. 2 years 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF OCATH? 1 YES 2 NO |
| ETED BY PHYSICIAN: MEDICAL CE | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in death) LAST PART II. Other aignificant conditions of the conditions of th | Cardiovas cause on each line. Cardiovas cause on each line. Cardiovas cause on each line. Cardiovas causeou Cardiomy op a conseou Due to (or as a conseou Due to (or as a conseou Ontributing to death but not real ONTRIBUTE TO CAUS OSPITAL: Xinpatient 2 = Er/Outpatient 3 = 28a. DATE of INJURY (Month, Day, Year) 28a. PLACE OF INJURY — At hombuilding, atc. (Specify) | Ular Even athy JENCE OF): BURCE OF): B | YES NO PLACE OF OEATH (Check NUURY AT NORK? YES 2 NO Ice 2 | 24a. WAS AN A PERFORM 1 VES 2 conly one) Other (Specify) 8d. OESCRIBE HOW IN City or Rown, State) | JURY OCCUREO | Interval Between Onset and Death 40 min. 2 years 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF OCATH? 1 YES 2 NO |
| ETED BY PHYSICIAN: MEDICAL CE | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in death) LAST PART II. Other aignificant conditions of the conditions of th | Cardiovas cause on each line. Cardiovas cause on each line. Cardiovas cause on each line. Cardiovas causeou Cardiomy op a conseou Due to (or as a conseou Due to (or as a conseou Ontributing to death but not real ONTRIBUTE TO CAUS OSPITAL: Xinpatient 2 = Er/Outpatient 3 = 28a. DATE of INJURY (Month, Day, Year) 28a. PLACE OF INJURY — At hombuilding, atc. (Specify) | Ular Even athy JENCE OF): JENCE OF): JENCE OF): Builting in the underlying in the | YES NO PLACE OF OEATH (Check NUURY AT NORK? YES 2 NO Ice 2 | 24a. WAS AN A PERFORM 1 VES 2 conly one) Other (Specify) 8d. OESCRIBE HOW IN St. LOCATION (Street ar City or Rown, State) | JURY OCCUREO | Interval Between Onset and Death 40 min. 2 years 24b. Were Autopsy Findings AMAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? 1 Yes 2 No |
| ED BY PHYSICIAN: MEDICAL CE | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in death) LAST PART II. Other aignificant conditions of the conditions of th | Cardiovas cause on each line. Cardiovas cause on each line. Cardiovas cause on each line. Cardiovas causeou Cardiomy op a conseou Due to (or as a conseou Due to (or as a conseou Ontributing to death but not real ONTRIBUTE TO CAUS OSPITAL: Xinpatient 2 = Er/Outpatient 3 = 28a. DATE of INJURY (Month, Day, Year) 28a. PLACE OF INJURY — At hombuilding, atc. (Specify) | Ular Even athy JENCE OF): JENCE OF): JENCE OF): Builting in the underlying in the | YES NO PLACE OF OEATH (Check NUURY AT NORK? YES 2 NO Ice 2 | art I. 24a. WAS AN A PERFORM 1 YES 2 Conly one) Other (Specify) 8d. OESCRIBE HOW IN City or Town, State) the cause(a) and mannine, data and place, and | JURY OCCUREO Ther as stated. I due to the cause | Interval Between Onset and Death 40 min. 2 years 24b. Were Autopsy Findings AMAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? 1 Yes 2 No |

29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

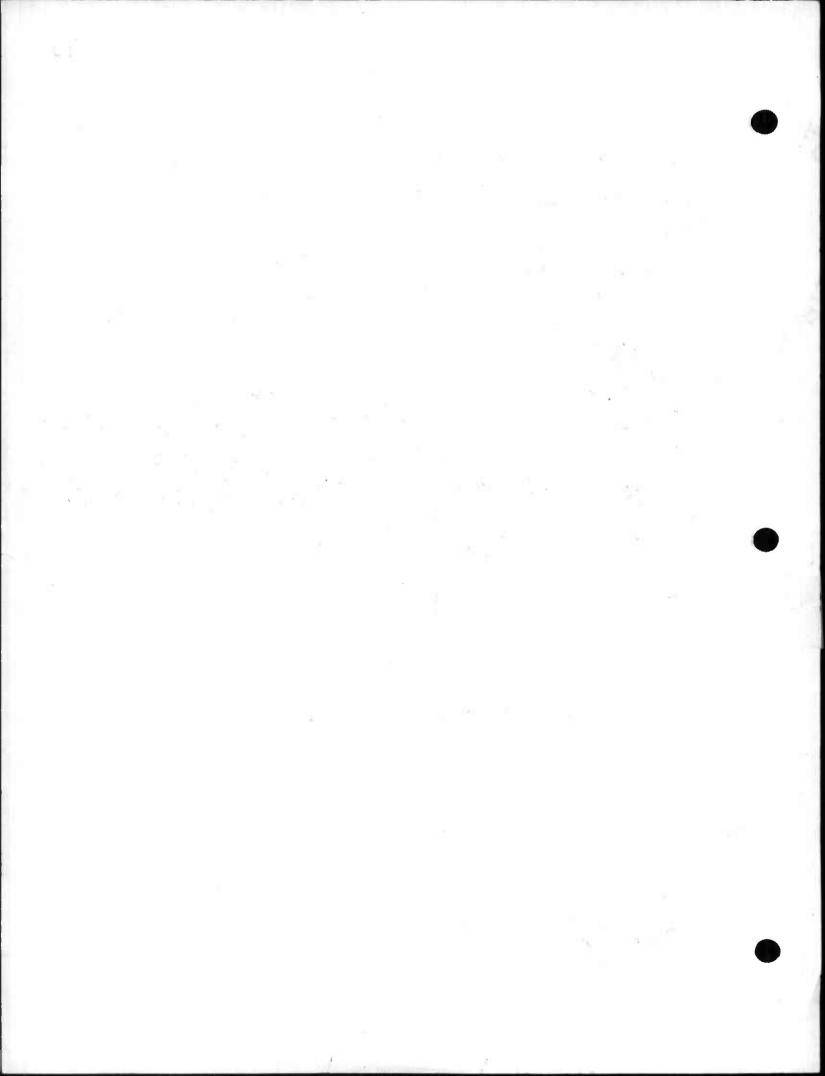
Dr. Inna Gendelsman C/O Maryland General Hospital
31. DATE FILED (MOOTH), Day 19894

32. REGISTRAR'S SIGNATURE

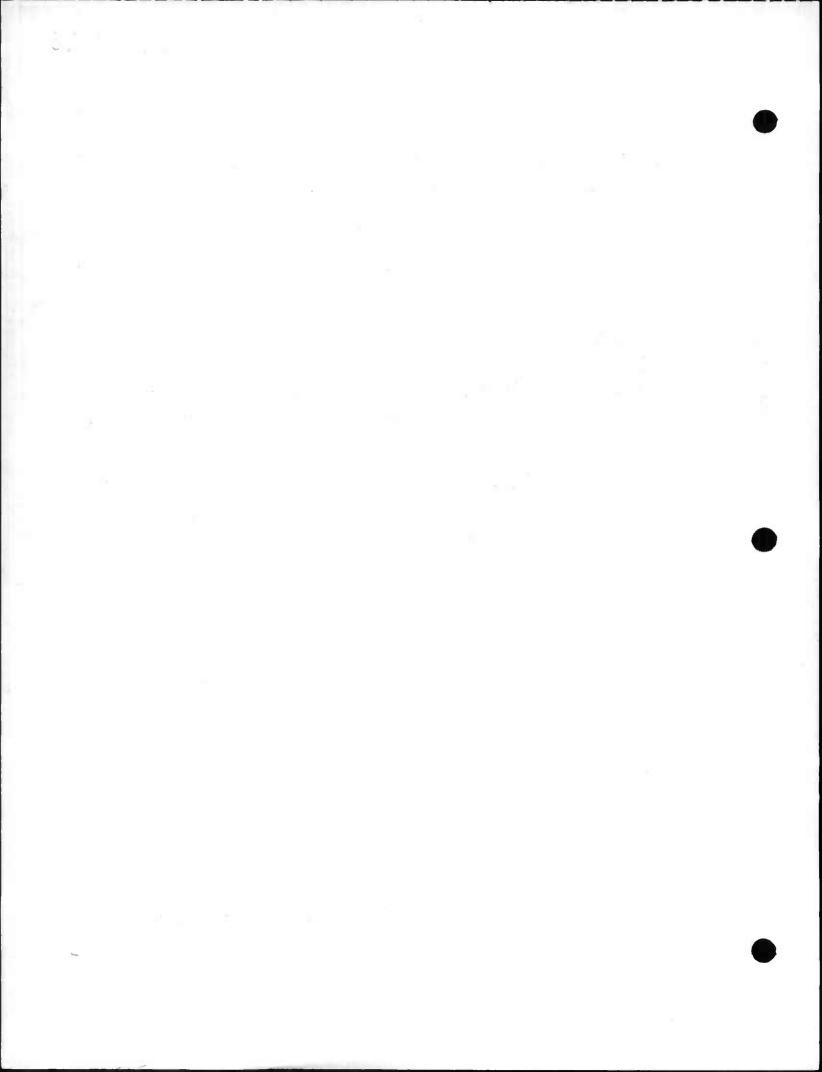
31. DATE FILED (MOOTH), Day 19894

July Samuel Files

DHMH-16 Rev 1/89

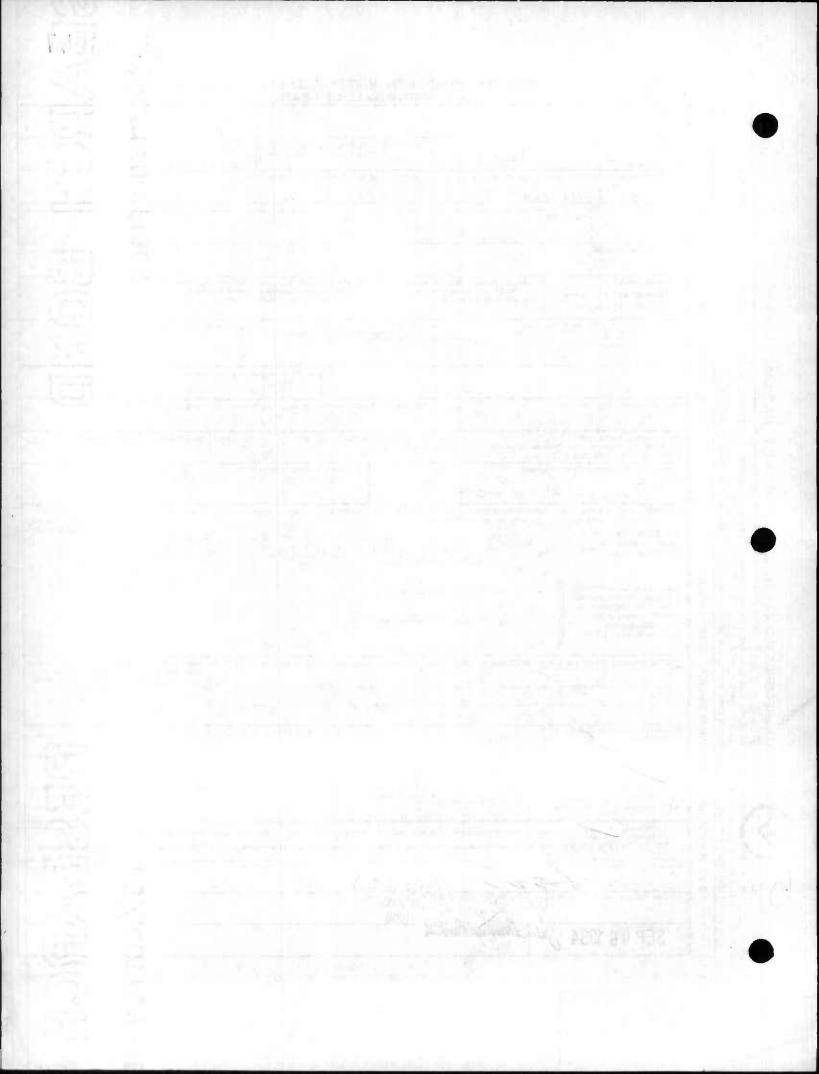


| | | 1 - FOR STATE REGISTRAR | STATE OF MARYLAND / DEPAR CERTIF | TMENT OF HEALTH AND I | MENTAL HYGIENE REG. NO. | |
|--|----------|---|--|--|---|---|
| | 1 | 1. DECEDENT'S NAME (First, Middle, Last) | | 4 | 2. DATE OF DEATH | 3. TIME OF DEATN |
| | | Gustavia | Williams | | August 14 199 | 94 1039 M |
| P | | 4. SOCIAL SECURITY NUMBER 216-42-0462 | 5. SEX 8. AGE (In yrs. last birthday) 1 | IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | (Morth, Dey, Year) 45 | Country) |
| 3 should | <u>~</u> | 9a. FACILITY NAME (If not institution, give st | | 96. CITY, TOWN OR LOCATION OF DE | EATH 9c. COUNT | Y OF DEATH |
| .23 | 5 | 5511 Bowleys La | ne-Apt. 2-C | Baltimore | | |
| Pages | DIRECTOR | 10a. STATE 10b. COUNTY | 10c. CIT | Ballo, | | 10d. INSIDE CITY LIMITSE 1 VES 2 NO |
| i. ınsit permit. | FUNERAL | 5511 Bowle | es Lane-Apt | 2-B 101. ZIP CODE 21201 | 6 10g. CITIZE | N OF WHAT COUNTRY? |
| 1215-0020 or attending physician. | BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 2. WAS DECEDENT EVER IN U.S. AHMIN FORCES? 1 YES 2 100 IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPAM If yes, specify Cuban, Maxica 1 VES 2 NO Specify | | 8. RACE — American Indian, Black, Whita, etc. Specify: Park |
| 21215 tal or attend | LETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary Secondary (0-12) | | Ot t | 16b. KIND OF BUSINESS/INDU | STRY |
| AND the hospit detached | COMPL | IT CATHERIS WEST TOTAL MINISTER AND | $\overline{\mathcal{D}}$ | ISALble | | |
| MARYLAND retained by the hospit 5 should be detached | ō | | MORKIS | Vic | ME (First, Middle, Maiden Surmarne) ORIA MC(| Cord |
| 83 43 | 2 | In Ha MC | MONMS 151 | ADDRESS (Street and Number or Ruralin | Reute Number, City or Town, State, Zip C | 21224 |
| 6 may | 100 | 20a. METNOD OF DISPOSITION 1 Description 2 Comments 3 Remo 4 Donation 5 Other (Specify) | val from State 20b. PLACE AND DATE Cometery, cramatory or of | | DATE 20c. LOCATION - CH | by or Town, State |
| Page al dire | | 21. SIGNATURE OF FUNERAL SERVICE LID | INSEE | 22. NAME AND ADDRESS OF FA | CILITY | 70 141 |
| BALTIMORE, ter death. Page 6 may b the funeral director. page | | Jeff ! | Jartle | Sefo Mil | lek# HB | condway |
| S = 5 | | 23. PART I. Enter the diseases, pr c | omplications that caused the death. Do noted in the cause on each line. | ot enter the mode of dying, suc | h as cardisc or reapiratory arres | Approximate |
| hin 24 Fille mation, | | IMMEDIATE CAUSE (Final disease or condition resulting in death) | DUE TO (OR AS A CONSEQUENCE OF | of Liver | | Onaet and Death |
| P 8 6 7 8 | | | Chronic | Alcaholism | | |
| 2 8 8 6 | TIO | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A CONSEQUENCE OF | 7: | | |
| e by cat | 2 | CAUSE (Disesse or injury | DUE TO (OR AS A CONSEQUENCE OF | | | |
| DS, P.O. B(the death certificate the attending physi I Mental Hygiene physicate | | that initiated events resulting in death) LAST | | ·): | | |
| 0 9 £ 2 = | AL CI | PART II. Other aignificant conditions | contributing to death but not resulting i | n the underlying cause given in | Part i. 24a. WAS AN AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| CRE that the ed by the and | 2 2 | Hepat | 155 | | PERFORMED? | AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| O 5 5 5 | MEDIC | | | | 1 NYES 2 NO partial | OF DEATH? 1 YES 2 □ NO |
| S 11 25 W | N | | IBUTE TO CAUSE OF DEATH YE | S 🗆 NO 🗆 UNCERTAIN | V 🗆 | |
| 一年 皇皇 | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE DF DEAT | OTHER: | | |
| F V SICIAN Certific | ે! ≿ ! | YES 2 NO 27. MANNER OF DEATN | 1 Inpetient 2 ER/Outpetient 3 DOA 26e. DATE OF INJURY 26b. TIMI | 4 Nursing Nome 5 XRasidence E OF 28c, INJURY AT | 8 Other (Specify) 26d. DESCRIBE HOW INJURY OCCU | 950 |
| O F # | Z A | 1 Natural 5 Pending | (Month, Day, Year) INJ | URY WORK? M 1 YES 2 NO | 200. DESCRIBE NOW INSONY COCC | ALD |
| VISIC | TED | 2 Accident Investigation 3 Suicide 6 Could not be determined | 26e. PLACE OF INJURY — At home, ferm, a building, etc. (Specify) | street, factory, office | 28f. LOCATION (Street and Number or City or Town, State) | Rural Route Number, |
| DI OR AL OR LE DIRI | 릴 | | IAN: To the beet of my knowledge, death occurre | | | |
| TO THE HOSPITAL TO THE FUNERAL De filed within 72 | COMPL | | : On the besis of exemination end/or investigation | n, in my opinion, death occured et the | time, date and place, end due to the | cause(e) end manner as stated. |
| THE Fled | H | 296. SIGNATURE AND TITLE OF CERTIFIER | in Christe in | 29c. LICENSE NUM | | SIGNED (Month, Day, Year) |
| 223 | 일 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEATH (ITEM 27) (Type, | Print) | E. l'Auc | rust 15 1994 |
| | | | 111 Pe | nn Street. Ba | ltimore Mars | rland 21201 |
| | 4 | 31. DATE FILED (MODIL) DOY (6) 1994 | 32. MEGISTRAR'S SIGNATURE | DELECT DO | THOLE, HALL | Tana 21201 |
| | | 021 00:00: | , | | | |



| COUNTION OF VITAL RECORDS, P.O. BOX 68760. |
|--|
| TO THE HINGTH. OR ATTACONG PHYSICIAN: The law requires that the death certificate be executed within yours after death. Page 6 may be retained by the hospital or attending physician. TO THE PINER CONTRACTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should |
| be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1 - FOR STATE OF N | | NENT OF HEALTH AND | MENTAL HYGIENE REG. NO. | |
|---------------|---|--|---|---|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) Benice Wood 4. Social Security Number 5. Sex | D-GIK | UNDER 1 YEAR IF UNDER 24 HRS. | 2. DATE OF DEATH MONTH DAY | 3. TIME OF DEATH YEAR 90 10 15 M 8. BIRTINPLACE (State or Foreign |
| | 2/4-22-0100 1 M 2 F | 88 YRS. MO | UNDER 1 YEAR IF UNDER 24 HHS. NTHS DAYS HOURS MIN. L. CITY, TOWN OR LOCATION OF DI | (Month, Day, Year) | COUNTY OF DEATH |
| TOR | PRESIDENCE OF DECEDENT | | Baltimore mid | | Saltimore |
| DIRECTOR | 10e. STATE 10b. COUNTY MD. | | OWN OR LOCATION TIMORE CITY | | 10d. INSIDE CITY LIMITS? ∑[[X] YES 2 □ NO |
| FUNERAL | 2721 MURA ST | | 21213 | 10g. | CITIZEN OF WHAT COUNTRY? USA |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married X Widowed 4 Divorced 12. WAS DECEDENT FORCES? 1 IF YES, GIVE V | TEVER IN U.S. ARMED YES 25 NO WAR OR DATES | 13. WAS DECENDENT OF NISPAI If yes, specify Cuban, Mexico 1 VES TO NO Specifi | in, Puarto Rican, etc.) | - 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 | life Do MOT use re | done during most of working tired.) | 16b. KIND OF BUSINESS | /INDUSTRY |
| BE COM | 17. FATNER'S NAME (First, Middle, Lest) ALBERT STEWART | | ESTH | 11000 | |
| 10 | 199. INFORMANT'S NAME (Type/Print) HATTIE HARRISON' | 19b. MAILING AD 2721 | DRESS (Street and Number or Rural MURA ST. BAI | Route Number, City or Town, State TIMORE MD. | 21213 |
| | 20a. METNOD OF DISPOSITION X Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 20b. PLACE AND DATE OF D cemetery, cremetory or other WOODLAWN | CEMETERY 22. NAME AND ADDRESS OF FA | 7/94 WOODI | LAWN MD. O4 N. CENTRAL A |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | use on each line. | nom boci | | Approximate Interval Batween Onset and Death |
| MEDICAL | PART II. Other algnificant conditions contributing to | death but not resulting in t | he underlying cause given in | Part I. 24a. WAS AN AUTOP PERFORMED? 1 YES 2 NO | AWAILABLE PRIOR TO COMPLETION OF CAUSE |
| CIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | 0 | 26. PLACE OF DEATH (C/ | neck only one) | |
| BY PHYSICIAN: | 1 YES 2 MO 1 Inpetient 2 C 27. MANNER OF DEATN 1 Metries 5 Pending 2 Accident Investigation | ER/Outpatient 3 DOA 4 | Nureing Home 5 Residence F 28c. INJURY AT | 5 Other (Specify) 28d. DESCRIBE HOW INJURY | OCCURED |
| | 3 Suicide 26a. PLACE (| OF INJURY — At home, farm, streete. (Specify) | et, tactory, office | 281. LOCATION (Street and Nur City or Town, State) | mber or Rural Route Number, |
| COMPLÉTED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of a MEDICAL EXAMINER: On the besis of a | | | | |
| TO BE C | 296. SICHATURE AND TITLE OF CERTIFIER | AKHANI | 2 UCENSE NU | MBER 29d. ▶ | DATE SIGNED (Morth, Day, Year) |
| | | ARK HEIGHTS AVE | nt) | | N 1801 |
| | 3. SEP 06 1994 July 2000 | A CONTRACTOR | | | H mil |



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DIVISION OF VITAL RECC

LAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with: hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | , | 1 | 4 | | | | | | 94 | 2 | 6048 |
|--------------------|--|--|----------------------------------|----------------------------------|-----------|--------------|------------|-----------|------------------------------|-----------------|---------------|------------|--|
| | 1 - FOR STATE REGISTRAR | STATE OF | MARYLAND C | DEPART | | | | | | YGIEN EG. NO | | | |
| | t. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF D | EATH | | | 3. TIME OF DEATH |
| - 6 | Margue | rite Lo | uise V | VALL | | | | | MONTH 8 | 31 | | 94 | 8:10 A M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (In yrs. Is | | | R 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF B | IRTH | | 8. BIRTI | IPLACE (State or Foreign |
| 1 | 217-22-3513 | 1 🗌 M 2 💢 F | 74 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, Day 3/22/ | | | Wavr | nesbaro.Pa. |
| | 9e. FACILITY NAME (If not institution, give s | street and number) | | | 9b. CIT | Y, TOWN | OR LOCATI | ON OF DE | | | 9c. COU | NTY OF D | |
| OR | Franklin Square | Hospital | | | | | | | | | Ba | ltim | ore |
| FUNERAL DIRECTOR | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT | | | Tage CITY | TOMBI | OR LOCAT | TION! | | | | | | |
| E | Maryland Balti | | | JUC. CITY, | , IUWN | OH LUCA | ION | | | | | | 10d. INSIDE CITY LIMITS? |
| וֶר ב | 10e. STREET AND NUMBER | IIIOEC . | | | - | T 40 | . ZIP COD | <i>E</i> | | | 1 40 - 0171 | 7511 05 1 | 1 TYES 2 NO |
| RA | | - D-1 | | | | 10 | | | | | | | WHAT COUNTRY? |
| N. | 9223 Philadelph | | IT EVER IN U.S. A | PMEO | 1 12 | WAS DEC | 212 | | HC ORIGIN? (Sp | | | USA | |
| | 1 Never Married 2 Married | FORCES? | YES 2 X | | 13. | If yes, sp | ecify Cube | m, Mexice | n, Puerto Ricen, | ecity rec | or No- | Black | E — American Indian, k, White, etc. |
| ВУ | 3 X Widowed 4 Divorced | IF TES, GIVE | MAR ON DATES | | | I [] YES | 2 LANO | Specify | y: | | | Spec | "White |
| ED | 15. DECEDENT'S EDU (Specify only highest grade | CATION | 16a, D | ECEDENT'S L | USUAL C | OCCUPATION | ON . | | 16b. KIN0 | OF BU | SINESS/INC | USTRY | |
| | Elemantery/Secondary (0-12) | College (1-4 or 5 | +) lin | Give kind of we s. Do NOT use | retired.) |) | SCOLWORKI | ng | | | | | |
| COMPLETED | 8 | | Hou | sewife | | | | | | Hous | ekeepi | ng | |
| 8 | 17. FATNER'S NAME (First, Middle, Last) | | | | | | 18. MOT | NER'S NA | ME (First, Middle | , Maiden | Sumame) | | |
| BE | Unknown Burkett | | | | | | | _ | Keckler | | | | |
| 9 | 19m. INFORMANT'S NAME (Type/Print) Harold R. Wall | | | | | | | | Ploute Number, Ci | | _ | Code) | |
| - | | . . | | 6001 G | | | | perlar | na, Ma. | 2068 | | | |
| | 20a METNOD OF DISPOSITION 1 ABurlel 2 Cremetlon 3 Rem | oval from State | | AND DATE OF | | | ime of | 9/3/ | DATE /O/ | | imore. | | own, State |
| | 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIE | CENSEE | _ I CLL KW | occi cci | _ | . NAME AI | In Anne | | | Date | шше | , Mu. | |
| | Monad T | - 1 | W | | | assahr | | | | | | | |
| - 1 | Unsom K | 1500C | OFT | 77. | | 7401 F | elair | Boac | Baltin | ore. | Md. 2 | 1236 | |
| | 23. PART I. Enter the diseases, or ahock, or heart failure. | complications the List only one car | ot caused the duse on each lin | esth. Do no a. | ot ente | r the mo | de of dy | Ing, suc | h ss cerdiec | or raspi | ratory arr | est, | Approximate Interval Between |
| - 1 | IMMEDIATE CAUSE (Final disease or condition | | 1 1 5 | Λ | 0 | - š . | | / | | 1 | F. | | Onset and Death |
| | resulting in daeth) | a. Pue m | OR AS A CONSE | Bu | De | Mi | 700 | and | cof In | rar | den | | IN & (Many ! Chie |
| _ | _ | DOE 10 | (UN AS A CONSE | OUENCE OF | 141 | 450 | U) | | | | | | |
| CERTIFICATION | Sequantially list conditions, if any, leading to immediate | b,DUE TO | (OR AS A CONSE | OUENCE OF |): | | - | | | | | | |
| 8 | cause. Entar UNDERLYING | • | | | | | | | | | | | 1 |
| <u> </u> | CAUSE (Disease or Injury that Initiated events | DUE TO | (OR AS A CONSE | OUENCE OF |): | | | | | | | | |
| 區 | resulting in death) LAST | d | | | | | | | | | | | |
| | PART II. Other significant condition | na contributing to | daath but not | reaulting In | n the u | ndarivino | Cause (| niven in | Part I 24a | WES AN | AUTOPSY | 245 | WERE AUTOPSY FINDINGS |
| <u>১</u> | Parkingan | Digeof | _ | | | , , , , , , | | | | PERFOR | IMED? | 1 | AMILABLE PRIOR TO COMPLETION OF CAUSE |
| 입 | | | | | | | | | _ 1 | YES 2 | NO | | OF DEATN? |
| 2 | | | | | | | | | - | | | | 1 YES 2 NO |
| Ž | 25. WAS CASE REFERRED TO MEDICAL | Franklin | Squar / | Jaspil | af | 26. PL | ACE OF D | EATN (Ch | eck only one) | | | | |
| PHYSICIAN: MEDICAL | EXAMINER? 1 YES 2 NO | HOSPITAL: | ER/Outpatient | | OTHE | | e 5 🗆 Re | eldence | 8 Other (Spe | icify) | | | |
| ٦ | 27. MANNER OF DEATN | 28a. DATE OF | | 28b. TIME INJU | OF | 28c. INJ | | | 28d. DESCRIB | _ | NJURY OC | URED | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | No | ne | | М | 1 🗆 , | |] NO | | | | | |
| | 3 Suicide 6 Could not be | 26e. PLACE (building. | of INJURY — At he atc. (Specify) | ome, ferm, st | reet, fac | ctory, offic | | | 261. LOCATION City or Tox | (Street a | end Number | or Rural F | Route Number, |
| | 4 Nomicide determined | | | | | | | | , | | | | |
| COMPLETED | | CIAN: To the best of | my knowledge, d | eath occurred | d at the | tima, data | and place | , end due | to the cause(a) | and mar | ner ea stat | ed. | |
| ŏ. | one) 2 MEDICAL EXAMINE | | | | | | | | | | | | e) end manner ee stated. |
| | 29b. SIGNATURE AND TITLE OF CERTIFIE | 2-200- | 0 20 | | | | 29c, LICI | ENSE NUN | | | | | (Month, Day, Year) |
| O BE | serate | mager | 770 | | | İ | 0 | 06 | 973 | | > 8 | 3/31 | 194 |
| ~ I | 20 MANE AND ADDRESS OF BERESH WE | | | | _ | | | | | | | - | |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

8100 Hartord Rd. Park U: (18)

MD 21234

31. DSEP 076 1994

A 32. REGISTRAR'S SIGNATURE

BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | REGISTRAR | | CERTIFIC | ATE OF | DEATH | REG. | NO. | | |
|------------------|--|---|-------------------------|---------------------|--------------------|--|------------------------------|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF OEATH | |
| | ANTHONY BERNARD | WOODEN | | | | AUGUST | 31,1994 | | |
| | 4. SOCIAL SECURITY NUMBER 5. S | | n yrs. lest birthday) # | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | RTHPLACE (State or Foreign | |
| | 213-86-9285 | X м 2 □ F 21 | YRS. | NTHS DAYS | HOURS MIN. | Jan. 14 | ,1973Ma | untry) | |
| | 9e. FACILITY NAME (If not institution, give street a | nd number) | 96 | CITY, TOWN O | R LOCATION OF D | EATH | 9c. COUNTY O | F DEATH | |
| TOR | JOHNS HOPKINS HOSPITAL BALTIMORE | | | | | | | | |
| Ä | 10e. STATE 10b. COUNTY | | 10c. CITY, T | OWN OR LOCAT | ION | | | 10d. INSIDE CITY | |
| ā | Maryland | | Bal | timore | | | | LIMITS? | |
| FUNERAL DIRECTOR | 1803 N. Castle St | treet | | | ZIP CODE | | | rican | |
| FUN | 1 Never Married 2 Married | WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 1 NO | If yes, spe | cify Cuban, Mexico | NIC ORIGIN? (Specify on, Puerlo Ricen, etc. | 8 | ACE — American Indian, lack, White, etc. | |
| В | 3 Widowed 4 Divorced | P YES, GIVE WAH ON DA | ILES | 1 U YES | 2X NO Specif | y: | s | Black | |
| | 15. DECEDENT'S EDUCATION (Specify only highest grade compo | | 18a, OECEDENT'S US | done during mos | N at of working | 16b. KIND OF | BUSINESS/INDUSTR | Y | |
| BE COMPLETED | Elementery/Secondary (0-12) Col | llege (1-4 or 5+) | Security | | d | Secur | ity Pat | ro1 | |
| MO | 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Mai | | | |
| C | Leroy Augustus Wo | ooden, Jr | • | | | ia Ann | | | |
| | 19a, INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or | | | |
| 2 | Jackie Ware | | | | | enue, B | | | |
| | 20a, METHOD OF DISPOSITION 1 | rom State 20b. | PLACE AND DATE OF E | elace) Ce | me tery | 9/6 C | LOCATION — City o atonsvi | Town, State | |
| | 21. DIGNATURE OF FUNCTIAL SERVICE LICENSE | | ukan | Marsh | all W. | Jones, J | r. Fune | ral HM PA | |
| _ | 23. PART I. Enter the diseases, or comp | aano | 1000 | 14101 | Edmond | son Ave | . Balti | more, MD212 | |
| | ahock, or heart fallura. List of iMMEDIATE CAUSE (Final disease or condition resulting in death) | GUNSH | CONSEQUENCE OF: | | | 57AP | apiratory arrest, | Approximate interval Between Onset and Death | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in dasth) LAST | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | |
| EDICAL (| PART II. Other significant conditions con | ntributing to death bu | ut not resulting in t | he underlying | cause given in | PER | FORMEO? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE | |
| | | | | | | | 2 🗆 NO | OF DEATH? 1 N YES 2 □ NO | |
| Σ :: | DID TOBACCO USE CONTRIBU | JTE TO CAUSE O | F DEATH YES | П по П | UNCERTAI | | | ZES Z NO | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | 26. PLACE OF DEATH (| | 0.1961(17(1) | | | | |
| Sic | | SPITAL: Inpatient 2 - ER/Outpi | | THER: | 5 🗆 Realdence | 6 Other (Specify) | | | |
| ¥ | 27. MANNER OF OEATH | 28e. DATE OF INJURY | 26b. TIME O | F 28c. INJU | JRY AT | | W INJURY OCCURED |) | |
| ВУР | 1 Neturel 5 Pending 2 Accident Investigation | 08-31-94 | 0327 | | | SUB: | JECT SH | OT | |
| | 3 Suicide 8 Could not be | 28e. PLACE OF INJURY building, etc. (Speci | — At home, farm, atre | nt, factory, office | F | 281. LOCATION (Str. City or Town, St | el end Number or Ru | | |
| | 4 Homicide determined | | STREET | T | | 1600 BLK | at a minute | NGJON, BALTIMOR | |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: 2 Medical Examiner: On | | | | | | | se(a) and manner as stated. | |
| | 296 SIGNATURE AND TITLE OF CERTIFIER | 00 | 7 | | 29c. LICENSE NUI | WBER | 29d, DATE SIGN | NED (Month, Day, Yeer) | |
| 8 | Munt 80 | W A | | | OCME | | AUGU | | |
| 임 | 30. NAME AND ADDRESS OF PERSON WHO COM | APLETED CAUSE OF DE | TH (ITEM 27) (Type, Pri | nt) | 00.11 | | 1 11000 | J_ J_ | |
| | MARIO P. GOLIE, | JR MD: | | Stree | et, Bal | timore, | Maryla | nd 21201 | |
| | SEP 0 6 1994 | 37. REGISTRAR'S SIGNA | Rardall | | | | | | |

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| | FOR 1 - STATE REGISTRAR | STATE OF MARY | LAND / DEPAR CERTIF | | | | | MENTA | L HYGIEN | | | |
|---------------|---|---|---|--------------------------|----|--------------------------------------|---|--|----------------------------|---|---------------------------------------|-----------------------------|
| | t. DECEDENT'S NAME (First, Middle, Last) | Robert | William | <u> </u> | Wa | ite | | 2. DATE MONT Sep | of DEATH | , 1 | 9'54 | 3. TIME OF OEATH 11:15 a. M |
| | 404-20-7992 | 1 🔀 M 2 🗌 F | (In yrs. lest birthday) 79 YRS. | IF UNDER 1 | - | IF UNDER : | 24 HRS. MIN. | 7. DATE OF BIRTH (Month, Day, Year) Aug 14, 1915 | | | 8. BIRTH Countr | PLACE (State or Foreign |
| TOR | 98. FACILITY NAME (If not institution, give street end number) 524 N. Charles Street Baltimore City RESIDENCE OF DECEDENT | | | | | | | | EATH | | | |
| DIRECTOR | 10e. STATE 10b. COUNTY Maryland | 10c. CITY | 10c. CITY, TOWN OR LOCATION Baltimore City | | | | | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | |
| FUNERAL | 524 N. Charles | | 101. ZIP CODE tog. CITIZEN OF 21201 United | | | | | | | | States | |
| B | 11. MARITAL STATUS 1 X Never Merried 2 Merried 3 Widowed 4 Divorced | R IN U.S. ARMED ES 2 XNO R DATES 13. WAS DECENDENT OF HISPANIC ORI If yee, specify Cuben, Maxican, Puer 1 \(\text{VES 2 (X NO } \) Specify: | | | | | , Puerlo | | | | , White, etc. | |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12) | (Give kind of w life. Do NOT us | DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refired.) Civil Servant U.S.G | | | | | | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | te | 18. MOTHER'S NAME (First, Middle, Melden Surname) Anna Davis | | | | | | | GOV | · · | |
| TO BE | 190. INFORMANT'S NAME (Type/Print) Ann L. King | 19b. MAILING | | | | | loute Num | | vn. State, Zip | - | 056 | |
| | 20a. METHOD OF DISPOSITION 1 Burlal 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of campatery, crematory or place place) 1 TO SET VICE CORP. 9/6 | | | | | | | DATE 20c. LOCATION — City or Town, State TOWSON Maryland | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Milton J Knight Jr 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214 | | | | | | | | | | | |
| | Approximate interval Batween Onset and Death Approximate interval Batween Onset and Death Approximate interval Batween Onset and Death OUE TO (OR/AS & CONSEQUENCE OF): | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d | | | | | | | | | | | |
| MEDICAL | PART II. Other aignificant conditions | n the underlying cause given in Part i. | | | | Part i. | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | | 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO | | | | | | | | | 1 NES 2 NO | | |
| YSICIAN | EXAMINER? | HOSPITAL: 1 YES 2 NO 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | | |
| у РНУ | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | ber) INJURY W | | | JURY AT 28d. DES DRK? YES 2 NO | | | ESCRIBE HOW INJURY OCCURED | | | |
| ETED B | 3 Suicide 8 Could not be detarmined | 28e. PLACE OF INJUR building, etc. (Sp | IURY — At home, ferm, street, fectory, office Specify) | | | | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | oute Number, |
| COMPLE | 29s. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(e) end manner ee stated. MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) end menner ea stated. | | | | | | | | | | | |
| # | 296. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUMBER | | | | BER | 2 / | 29d. DATI | SIGNED | (Moglin, Day, Year) | |
| 2 | 1900 F. 10A | COMPLETED CAUSE OF D | EATH (ITEM 27) (Type, | CUY: BAUTIMORE Mb. 21239 | | | | | | | 117' | |
| | SEP 0 6 1994 | THE OIST PLESSED | NATURAL LA | | | | | | | | | |

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| DF VITAL RECORDS, P.O. BOX 687 | * ** ** ** |
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| DIVISION O | October Spinster |

hours after death. Page 6 may be retained by the hospital or attending physician. THE PROPERTY OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | _ | REGISTRAR | | | JEHIT | CATE | OF DEAT | н | REG. NO. | | | |
|--|------------|--|----------------------|-----------------|-----------------|-----------------|-----------------------------|---|--------------------------------------|-----------------------------|---------------------------------|--|
| | | t. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF DEATH MONTH DA | | 3. TIME OF DEATH | |
| | | Cornelia Amelia Walker | | | | | | | September 3 | 994 10:10 am | | |
| | | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. | last birthday) | IF UNDER 1 YE | AR IF UNDER 2 | \rightarrow | 7. DATE OF BIRTN | 17 | 6. BIRTHPLACE (State or Foreign | |
| | | 215-56-5333 | 1 🗌 M 2 💢 F | 92 | YRS. | MONTHS DA | Y8 HOURS | MIN. | July 31, | 1902 | Maryland | |
| 3 should | | 9e. FACILITY NAME (If not institution, give st | reet and number) | | | 9b. CITY, TO | WN OR LOCATION | N OF DEA | | | TY OF DEATH | |
| 33 | ۳. | 8415 Bellona Lane | Apt. | # 509 | | Т | owson | | | Ra | ltimono | |
| 1, 2, | DIRECTOR | RESIDENCE OF DECEDENT | | | | | | | | | TETHIOTE | |
| ages | # | 10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. IN | | | | | | | | 10d. INSIDE CITY LIMITS? | | |
| ₩. | □ | Maryland Balt | imore | | | Tows | on | | | | 1 YES 2 NO | |
| регл | ¥ | toe. STREET AND NUMBER | | | | | 101. ZIP CODE | | | 10g. CITIZE | EN OF WHAT COUNTRY? | |
| the burial-transit permit. Pages 1, | FUNERAL | 8415 Bellona La |) | | 212 | 204 | | Unit | ted States | | | |
| ial-tr | 5 | 11, MARITAL STATUS | ARMED | 13. WAS | DECENDENT OF | NISPANI | C ORIGIN? (Specify Yes | or No — 1 | 14. RACE — American Indian, | | | |
| por | ВУБ | 1 Never Married 2 Married 3 X Widowed 4 Divorced | YES 2 X | | | | | , Puarto Rican, atc.) | Black, White, etc. Specify: 111 - 1 | | | |
| as th | | | | | | | | | White | | | |
| use | COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | CATION completed) | | (Give kind of w | USUAL OCCUP | PATION g most of working | , | 16b. KIND OF BUS | SINESS/INDU | STRY | |
| Tor I | ۳ | Elementary/Secondary (0-12) | College (1-4 or 5+ |) ' | life. Do NOT us | | | | | | | |
| achec | M | 12 yr's | | | НО | usewif | е | | | | | |
| detach | 8 | 17. FATNER'S NAME (First, Middle, Last) | Missis | 1 7 | | | | | E (First, Middle, Maiden | Sumame) | | |
| od be | BE | Conrad | wunc | lerlich | | | | | lmina | | Ripple | |
| 5 should notified | 0 | 19e. INFORMANT'S NAME (Type/Print) | 0 11 | | | | | | oute Number, City or Town | | | |
| be n | _ | Mrs. Elaine E. Mc | Lartny | | | | Hill R | d. | Coopersbu | rg, Pe | enna. 18036 | |
| and completely filled in by the funeral director, page 5 should be detached for burial, cremation, or removal. natic event, the medical examiner must be notified at once. | | 20a, METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Remo | oval from State | | | F DISPOSITION | | | 1 | | Ity or Town, State | |
| irecto | | 4 Donetion 5 Other (Specify) | | | | ge Cen | | 9/6/ | | ltimor | re Maryland | |
| nine | 1 | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Paul L. Hartsock, Jr. 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. | | | | | | | | | | |
| tuneral dir J. examiner | | | | | | | | | | | | |
| mova Ical | | 22 DART I Enter the diseases or complication that the task is a second section of the section of the section | | | | | | | | | | |
| d in by th or remove medical | | shock, or heart fellure. List only one ceuse on each line. | | | | | | | | | | |
| y filler tion, | | IMMEDIATE CAUSE (Finel disease or condition | /// | 1/1 | | / | 11, | 1/5 | TAKET CONT | | Onset and Death | |
| ompletely al, crema event, | H | reaulting in deeth) a. DUE TO (OR AS A CONSEQUENCE OF) | | | | | | | | | | |
| ial, c | _ | DUE TO (OH AS A COMBEGUENCE OF) | | | | | | | | | | |
| Sician and c prior to buria traumatic | CATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated evente Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| attending physician a ntal Hygiene prior to y, or other traum | AT | | | | | | | | | | | |
| ing physique p | 윤 | | | | | | | | | | | |
| Hygie or ot | RTIFI | resulting in death) LAST | | | | | | | | | | |
| the atter Mental njury, o | S | | | | | | | | | | | |
| th and Menta any injury, | A | PART II. Other significent conditions | contributing to | deeth but not | t resulting i | n the under | ying ceuse giv | ven in P | | | 24b. WERE AUTOPSY FINDINGS | |
| th an | DICAL | | | | | PERFORMED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | | |
| Sign deal | W II | | | | | | | | | 26 | OF DEATH? | |
| has been s Dept. of H n 23 shov | Σ | DID TOBACCO USE CONTR | IBUTE TO CA | USE OF DE | ATH YE | s II NO | □ UNCE | PTAIN | | | 1 1 1 1 1 1 1 1 1 | |
| bas bept | CIAN | 25. WAS CASE REFERRED TO MEDICAL | | | | N (Check only o | | | | | | |
| certificate h h the State [d, or item | Sic | EXAMINER? | HOSPITAL: | ER/Outpatient | 3 🗆 DOA | OTHER: | Home & X Beel | Idence & | Other (Specify) | | | |
| th the | ≟ ∥ | 27. MANNER OF DEATN | 28a. DATE OF | INJURY | 28b. TIME | OF 28c. | INJURY AT | _ | 28d. DESCRIBE HOW I | NJURY OCCU | RED | |
| this with | ∠ P | 1 Natural 5 Pending | (Month, De | ly, Year) | INJ | | WORK? | | | | 1120 | |
| 4 5 M | œ | Accident Investigation "1 YES 2 NO 28e PLACE OF IN HIPY At home form effect technical action will be a second action." | | | | | | | | | | |
| after 28 i | 8 | 3 Suicide 8 Could not be determined 286. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 286. LOCATION (Street and Number or Rural Route Number, City or Yown, State) | | | | | | | | | | |
| DIRECTOR: hours after item 28 is | 9 | 29a, CERTIFIER | | | | | | | | | | |
| 12 H | MPL | (Check only 122 CEHTIFTING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. | | | | | | | | | | |
| 3113 | 8 | and place, and due to the cause(a) and manner as stated. | | | | | | | | | | |
| # 22 5 | F. | 296. SIGNATURE AND TITLE OR CERTIFIER 296. DATE SIGNED (Modifit, Day, Year) | | | | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | 19 | 9/2/94 | | |
| | | | | | | | | | 116. | iconsite PHUL | | |
| **1.0 | | NO, Saniels, V | C. VAY | 10h /1 | LENOY | ral o | HOSDIC | رض د | BATH | non | 2/2/2 | |
| | | 31. DATE FILED (Month Day Year) | 7 J2. PEGISTRA | L'S SIGNATURE | - | | 1 | | 1111111 | 181 | 7 | |
| | | DEL 0 0 1991 | | • | - | | V | | | | | |
| L | | | | | | | | | | | | |

fig.

Pages 1, 2, 3 should

permit.

use as the bunal-transit

10

hours after death. Page 6 may be retained by the hospital or attending physician.

the funeral director, page 5 should be detached

notified at

must

event, the medical examiner

or removal

attending physician and completely filled in by

prior to burial, traumatic

Mental Hygiene

this certificate has been signed by the with the State Dept. of Health and Mer

DIRECTOR: After the hours after death w

THE HOSPITAL (THE FUNERAL D TO THE FUNERAL C be filed within 72 h IMPORTANT: If It

or other

CERTIFICATION

MEDICAL 23 shows any

PHYSICIAN:

BY

COMPLETED

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is marked,

28

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

DIRECTOR

FUNERAL

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. OECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATN 3. TIME OF DEATN YEAR FRED LEE WHITE, JR AUGUST 30 1994 7:16 SOCIAL SECURITY NUMBER 5. SE) IF UNDER 1 YEAR 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. DAYS. HOURS 5-1-49 laryland 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 3710 w.BELVEDERE AVENUE BALTIMORE RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 YES 2 NO Maryland Baltimore 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? W. Belvedere 710 U.S. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. APPLED FORCES? 1 YES 2 NO 14. RACE Black, 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No American Indian,
 White, etc. If yes, specity Cutrin, Mexican, Puerto Ricen, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 Merried IF YES, GIVE WAR OR DATES 3 Widowed 4 Divorced Black 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEOENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondery (0-12) College (1-4 or 5+) Gth Brick Layer 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) White Fred Pannie Valen INFORMANT'S NAME (TV METHOD OF DISPOSITIO 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State 5 0 22. NAME AND ADDRESS OF FACILITY Gary P. March Fred Hilton Pass 70 21229 the diseases, of complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate intarval Between iMMEDIATE AUSE (Final disease ex endition resulting in death) Onset and Death a. FATTY LIVER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE YES 2 NO OF DEATNS 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO INCERTAIN I 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) HOSPITAL OTHER: 1 XYES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 X Rasidence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28c, INJURY AT 28b. TIME OF INJURY 26d. DESCRIBE HOW INJURY OCCURED 1 XX Natural 1 TYES 2 NO Investigation 2 Accident 26e. PLACE OF INJURY — At home, farm, street, tactory, office building, etc. (Specify) 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Nomicide 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(a) and menner as attated. 2 X MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(s) end manner as stated. 29b. SIGNATUS

29c. LICENSE NUMBER

O.C.M.E.

▶AUGUST 30,1994 111 Penn Street, Baltimore, Maryland 21201

29d. DATE SIGNED (Month, Day, Year)

OF DEATN (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE i Danden-Rudall

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DHMH-16 Rev 1/89

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH Beatrice 10:15 AM 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH ith, Day, Year, 10 1 M 2 W 6 7 YRS. DAYS HOURS NEW **JERSEY** should 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH UM. & MD Hederl DIRECTOR permit. Pages 1, 2, 3 BALTIMORE RESIDENCE 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND ANNE ARUNDEL GLEN BURNIE 1 YES 2XXNO FUNERAL 10e STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 102 N. CRAIN HIGHWAY-APT:875 21061 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—if yes, specify Cuban, Mexican, Puario Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 3 Widowed 4 Divorced WHITE ETED 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION the hospital or atter 16b, KIND OF BUSINESS/INDUSTRY use (Specify only high page 5 should be detached; for Elementary/Secondary (0-12) College (1-4 or 5+) 12 COMPL 0 HOUSEWIFE HOMEMAKER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) LOUIS Page 6 may be retained by ₩ R. GRINER **GLADYS** Η. HESS BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 SUE A. HENRY 235 HAMMARLEE ROAD-GLEN BURNIE, MD. 21061 9 20a. METHOD OF DISPOSITION
1 ☐ Burlal 22 Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — Cify or Town, State must the funeral director, METRO CREMATORY, INC. 4 Donetion 5 Other (Specify) 9/7 CATONSVILLE, MD. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 2106 426 CRAIN HWY.S.W.GLEN BURNIE, MD. 21061 medical 23. PART I. Enter the diseases, or complice shock, or heart failure. Liet or one that caused the death. Do not enter the mode of dying, auch as cerdiec or respiratory arrest, completely filled in by Interval Between ŏ **Onset and Death** IMMEDIATE CAUSE (Finel cremation, the disease or condition myocardial event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF in and cont to burial, HChemic traumatic Condionello CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): attending physician ntal Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in deeth) LAST 0 in signed by the atten-Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PERFORMED? any 1 YES 2 NO OF DEATH? Shows 1 YES 2 NO t, of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO E N/A . OR ATTENDING PHYSICIAN: The law of DIRECTOR: After this certificate has be hours after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Hem HOSPITAL:
1 Minpetiant 2 - ER/Outpetient 3 - DOA OTHER: 1 YES 2 100 4 Nursing Home 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28d. DESCRIBE HOW INJURY OCCURED 28c, INJURY AT WORK? marked, 1 Natural 5 Pending 1 YES 2 NO ΒY Investigation 2 Accident Suicide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 89 COMPLETED 8 Could not be 4 Homicide 28 determined Hem 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. THE HOSPITAL O THE FUNERAL D filed within 72 ho (Check only one) = 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. IMPORTANT 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE S/GNED (Month, Day, Year) BE 7210 223 5 WHO COMPLETED CAME OF DEATH (ITEM 27) (Type, Print) 30. NAME AND ADDRESS OF PERSON Greson

CROCENZI

TODD

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 2, 1994 Sept. RICHARD YOUNG HANS 7:50 A. 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH S. BIRTHPLACE (State or Foreign HOURS 63 YRS. 143-26-3623 1 😾 M 2 🗌 F Penn. 12-14-1930 9a. FACILITY NAME (If not institution, give street and number, 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR permit, Pages 1, 2, 3 5619 Pioneer Dr. Baltimore City RESIDENCE OF DECEDENT 10a, STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Baltimore City 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 5610 Pioneer Dr. 21214 U.S. ours after death, Page 6 may be retained by the hospital or attending physician 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-BALTIMORE, MARYLAND 21215-0020 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 TES 2 NO BY Specify: 3 Widowed 4 Divorced White COMPLETED 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig ntary/Secondary (0-12) 8 yr's Truck Driver ATTS. 17. FATHER'S NAME (First Middle Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) ¥ Richard Young Margaret BE Curcio notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Louise C. Young Same as #10 e 20a. METHOO OF DISPOSITION
1 ☐ Burlai 2 ※ Cremation 3 ☐ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must 4 Donation 5 Other (Specify) Towson, Md top Serv, 9/6/94 medicai examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Baltimore, MD 21214 ray Ruck, Inc. 5305 Harford Rd Leonard J. signed by the attending physician and completely filled in by the Health and Mental Hygiene prior to burial, cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximate ahock, or heert failure. List only one cause on each line Interval Batween IMMEDIATE CAUSE (Final Onset and Death the disease or condition resulting in death) an event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initisted events reaulting in deeth) LAST 10 PART ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO any COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 TES 2 NO to PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE DF DEATH (Check only one) certificate h HOSPITAL 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) d the 27. MANNED OF DEATH 28c. INJURY AT WORK? 28e. DATE OF INJURY (Month, Day, Year) 28d. DESCRIBE HOW INJURY OCCURED marked, With this 1 Natural 5 Pending 1 YES 2 NO BY fter 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide OR 29e. CERTIFIER 1 (CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 _ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 00 TO THE HOSP!
TO THE FLINE!
De filed within 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 19 9 0. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert Hsiao, Υ. M.D.Good Samaritan Hospital 32. REGISTRAR'S SIGNATURE

ITEMS: 23 PART I, 27, PER MEO FILM G-715 9/21/94 t.t

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1 - STATE REGISTRAR | SIAIL OF MARTE | CERTIFIC | | F DEATH | U MEN | REG. NO. | | | |
|--|--|--|-----------------|-------------------------------------|-----------|---|-------------|-----------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | DATE OF DEATH | | | 3. TIME OF DEATH |
| GERALD E. A | UTHUR AR | THUR | | | " | SEPT C | 13 | YEAR Q.4 | 12:25P M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 8. AGE | | IF UNDER 1 YEA | | | ATE OF BIRTH | | 8. BIRTH | PLACE (State or Foreign |
| 216-48-7945 | 1XXM 2 □ F 46 | YRS. | MONTHS DAY | 18 HOURS MIN | Ma | Month, Day, Year) Ly 8, 1948 | | Mai | yland |
| 9a. FACILITY NAME (If not institution, give str | reet and number) | 40 | 9b. CITY, TOV | N OR LOCATION O | | | 9c. COUNT | TY OF D | EATH |
| 6400 PULASKI | HGY ROOM | 19 | BAL | TIMORE | CIT | Y | | | |
| RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 40- OITV | TOWN OR LO | 0471011 | | | | | |
| | moll Country | 10c. C111, | TOWN OR EC | | | 11. | | | 10d. INSIDE CITY LIMITS? |
| 10e, STREET AND NUMBER | roll County | | | 10f. ZIP CODE | svil | rre | 40. 01717 | | 1 X YES 2 NO |
| 7526 Main Stans | a. h | | | | | | | | HAT COUNTRY? |
| 7526 Main Stre | 12. WAS DECEDENT EVER I | N U.S. ARMED | 13. WAS | 2178 DECENDENT OF HIS | | IIGIN2 (Specify Yea | | U.S. | A • — American Indian, |
| 1 Never Merried 2 Merried 3 Widowed 4 Divorced | FORCES? 1 X YES | | If yea | , specify Cuban, Ma YES 2 XNO Sp | xicen, Pu | erto Rican, etc.) | | Black Specif | , White, etc. |
| 15. DECEOENT'S EDUC (Specify only highest grade of | | 16e. DECEOENT'S U | | | | 16b. KIND OF BUS | INESS/INDU | STRY | WIIICC |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use | retired.) | most of working | | | | | |
| 12 | | Truck | Drive | r | | Ti | cansp | orta | tion |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S | NAME (F | irst, Middle, Maiden | Surname) . | | |
| George A | rthur | | | He | len | Lowman | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Jennifer Tw | igg | | | et and Number or Ru ley Spri | | | | | MD 21502 |
| 20e. METHOD OF DISPOSITION 1 Burial 2 Cremellon 3 Ramo 4 Donation 5 Other (Specify) | val from State cen | PLACE AND DATE OF netery, cremetory or other | er place) | | 1 | | ATION — CI | | . 41 |
| 21. SIGNATURE OF FUNERAL SERVICE LICE | ENSEE / | arrison I | | Cemeter | | | ings | Mıll | s, MD |
| · Blian | L. Haid | 1 | HAI | GHT FUNE kesville | ERAL | HOME (P | | | |
| 23. PART I. Enter the diseases, or co | omplications that cause | the death. Do no | t enter the | mode of dving, a | such as | cardiac or reapi | atory arre | - / 9 _ st, | Approximate |
| ahock, or heart fallure. L iMMEDIATE CAUSE (Final disease or condition resulting in desth) | HYPERTENSIVE | | | EASE | | | | | interval Between Onset and Death |
| Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | CONSEQUENCE OF): | | | 7 1 | | | | |
| PART II. Other aignificant conditions DID TOBACCO USE CONTR | | F DEATH YES | □ NO | UNCERT | | 1 YES 2 | WEO? | 24b. | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEATH | (Check only o | ne) | | | 140 m | - | DOOM |
| 1 PAYES 2 NO 27. MANNER OF DEATH | 1 Inpatient 2 ER/Outp | | | Iome 5 Residen | | Other (Specify) | MOT | | ROOM |
| 1 Natural 5 Pending | (Month, Day, Year) | 28b. TIME | RY . | INJURY AT WORK? | 28d. | DEŞCRIBE HOW IN | JURY OCCU | RED | |
| 2 Accident Investigation | 25a PLACE OF IN HIRV | A1 hama 4 | | YES 2 NO | - | | | | |
| 3 Suicide 5 Could not be determined | 26e. PLACE OF INJURY building, stc. (Spec | — At nome, term, str | eat, factory, o | TRICE | | LOCATION (Street as City or Town, State) | nd Number o | r Aurel A | oute Number, |
| | IAN: To the best of my know | | | | | | | | and manner ea stated. |
| 29b. SIGNATURE NO TITLE OF CERTIFIER | 11 | | | 29c. LICENSE | NUMBER | | 29d. DATE S | SIGNEO | (Month, Day, Year) |
| Theodore 1 | U. King | 1, M. | 1 | O.CI | м.Е. | | | EPT | 4/94 |
| 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF SE 1. KIN (11) | Penn S | treet | , Balt | imo | re, Mar | ylan | d 2 | 1201 |
| 31. DATE FILEO (Month, Day, Year) | 32 REGISTRAR'S SIGN | ATURE | | | | | | _ | |

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-16 Rev 1/89

| | | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPAI CERTIF | RTMENT OF I | HEALTH AND I | MENTAL HYGIE | | | |
|---|---------------|---|---|------------------------------|------------------------------------|---|--|----------------------|--|-------|
| | | 1. DECEDENT'S NAME (First, Middle, Lest) | E. ALPIG | 011/1 | | | 2. DATE OF DEATH | 54 9 | SAN 12'22 | Рм |
| PIN | | 4. SOCIAL SECURITY NUMBER 1 218-01-7719 | 1 □ M 2 😾 F 79 | (In yrs. lest birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 5-9-19 | | BIRTHPLACE (State or Fore Country) rrisburg, | |
| 2, 3 should | OR | 90. FACILITY NAME (If not institution, give st John Hopkins Ba RESIDENCE OF DECEDENT | | Ctr. | | or location of de timore | EATH | 9c. COUNTY | OF DEATH | |
| Pages 1, | DIRECTO | 10a. STATE 10b. COUNTY | | 10c. CI | y, town on Loca undalk | TION | | | 10d. INSIDE CITY LIMITS? | |
| permit. | | 106. STREET AND NUMBER 2404 Keyway | | | 10 | 1222 | | 10g. CITIZEI | 1 YES 27 N | 10 |
| -0020 ing physician. the bunal-transit | FUNERAL | 11. MARITAL STATUS 1 Never Married 2X Married | 12. WAS DECEDENT EVER IN FORCES? 1 VES | 2 NO | 13. WAS DEC | CENDENT OF HISPAN pecify Cuban, Maxica | IIC ORIGIN? (Specify ' | | . RACE — American Indian Black, White, atc. | ι, |
| S S S | ED BY | 3 Wildowed 4 Divorced 15. DECEOENT'S EDUC | | 18a. DECEDENT'S | USUAL OCCUPATI | S 2 NO Specify | | BUSINESS/INDUS | White | |
| D 21 | 1 1 | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | lile. Do NOT u | work done during m se retired.) | ost of working | Own | | | |
| e de la | COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | ewire | | ME (First, Middle, Maid | | | |
| MARY retained by 5 should be notified at | O BE | John Staley 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street | | e Allen Route Number, City or 1 | own, State, Zip Co | ode) | |
| . A & & | ۲ | Miss Marianne | | | | | ndalk, | | | |
| 6 m etor, | | 20s. METHOD OF DISPOSITION 1 VBuriel 2 Cremation 3 Ramo 4 Donation 5 Other (Specify) | ovel from State cem | etery, cremetory or i | of DISPOSITION (Nother piece) | | 9-7-94 | LOCATION — CH | | |
| deati fun | | 21. SIGNATURE OF FUNERAL SERVICE INC | Peter S | .Ashton | Brad: | nd address of fail | ton Fune | eral H | ome; 1722. alto., Md. | |
| BA nours after d ed in by the or removal. medical es | | 23. PART i. Enter the diseases, or c shock, or heart fellure. I IMMEDIATE CAUSE (Fine) | | the death. Do | not enter the mo | ode of dying, suc | h ss cardiac or res | piratory arres | t, Approximat Interval Bet Onset and I | lween |
| ompletely filled or, cremation, o | | disease or condition reaulting in death) | LACTIC DUE TO (OR AS A | ACID | | | | | / | Death |
| OX 6876 be executed sician and coming to burial, a traumatic events. | NOI | Sequentially list conditions, | SEPTIC DUE TO (OR AS A | SHO | PI: | | | | İ | |
| Per physicate | CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | OUE TO (OR AS A | CONSEQUENCE O | F): | | | | | |
| 마음등 | CERT | resulting in deeth) LAST | ı | v | | | | | | |
| A This and W Injury | A I | PART II. Other eignificent condition | e contributing to deeth be | ut not resulting | In the underlyin | ng ceuse given in | PERF | AN AUTOPSY ORMED? | 24b. WERE AUTOPSY FINE AWAILABLE PRIOR TO | 0 |
| required by the shown | : MEDIC | | | | | | 1 YES | 3 NO | COMPLETION OF CAL OF DEATH? | |
| ▼ 9 = = = | SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | LACE OF DEATH (Ch | eck only one) | | | |
| SIGIAN- Certific The Sign | PHYSI | 1 YES 2 NO 27. MANNER OF CEATH | 1 Inpatiant 2 ER/Outp 28a. OATE OF INJURY | etlent 3 DOA | | ne 5 🗆 Residence | 6 Other (Specify) 28d. DE\$CRIBE HOV | V IN ILIEN OCCUP | 350 | |
| E # 5 E | 10 VB | 1 Natural 5 Pending Investigation | (Month, Day, Year) 28a. PLACE OF INJURY | IN | M 1 | YES 2 NO | | | | |
| OH ATTO | | 3 Suicida 8 Could not be detarmined | building, atc. (Spec | :ify) | | | 28t. LOCATION (Stree City or Town, Sta | te) | Hurai Houte Number, | |
| 元 元代 田 | COMPL | | CIAN: To the best of my knowl R: On the basis of examination | | | | | | ause(a) and manner as stat | ted. |
| TO THE HOSFIT TO THE FUNER be filed within | TO BE | 390. SIGNATURE AND TITLE OF PETTIFORM | ly 1 | 4.0. | | 29c. LICENSE NUM | IBER | 29d. DATE S | IGNED (Marth, Day, Year) | |
| , | | GLEN C. M. | , , , | n.O. | | Castern | Ave. [| Balto | . HO 212 | 74 |
| | | 31. DATE TEPMOM! POJ994 | F12. PENTINGES, SIGN | FURENCE | | | | | DHAIL 14 | |

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| BALTIMORE, MARYLAND 21215-0020 | SPITE DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within cours after death. Page 6 may be retained by the hospital or attending physician. | ther this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans |
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| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | ithi | letely fille |
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| IS | ATE. | CTOR |
| 2 | DR / | DIRE |
| _ | SPITAL | WEHAL DIRECTOR: Aft |

| | FOR STATE REGISTRAR | STATE OF MARYLAN | ID / DEPARTMENT (CERTIFICATE | | MENTAL | HYGIENE REG. NO. | | |
|--------------|--|---|--|--|-------------------------------|--------------------------------------|---------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Las | ANN BK | RUZDOSI | Kİ | SEP. | F DEATH DAY | 1994 | 3. TIME OF DEATH 3. 45A |
| | 4. SOCIAL SECURITY NUMBER 073-30-2334 9a. FACILITY NAME (If not institution, give | 10 M 2 PF 54 | YRS. | EAR IF UNDER 24 HRS. AYS HOURS MIN. WWN OR LOCATION OF D | APRI | L 29,1 | 0 | BIRTHPLACE (State or Foreign Country) ON 174-144-1997 TON OF DEATH |
| DIRECTOR | 3/14 SUMMIT RESIDENCE OF DECEDENT 10s. STATE 10b. COU | T AVE | 10c. CITY, TOWN OR | ARNEY | | | BA | LTO. CD. |
| | MARYLAND B | ALTIMORE G | | 101. ZIP CODE | | | 10g. CITIZEN | 1 YES 2 NO |
| FUNERAL | 31/4 SUMMI | 12. WAS DECEDENT EVER IN U. FORCES? 1 YES | | 2/23 S DECENDENT OF HISPA | NIC ORIGIN? | (Specify Yea o | r No- 14. | RACE — American Indian, Block, White, atc. |
| ED BY | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DATE | | YES 2 NO Speci | ily: | KIND OF BUSI | IESS/INDLIST | Specify: WHITE |
| | (Specify only highest gra | | (Give kind of work done duri life. Do NOT use retired.) | ng most of working | 160. | KIND OF BUSI | IE33/INDU31 | |
| BE COMPL | 17. FATHER'S NAME (First, Middle, Last) MARTIN S | TENAD | | 18. MOTHER'S N | AME (First, M | iddle, Maiden Su | mame) UEL | LEK |
| 5 | 19a. INFORMANT'S NAME (Type/Print) OYNTHIA BRU 20a. METHOD OF DISFOSITION | IZDOSKI | 19b. MAILING ADDRESS (S 28/8 D/ | LON ST | · Bh | 200. | M). | 21224 |
| | 1 Buriet 2 Commetten 3 R 4 Donation 5 Other (Specify) | amovel from Stata cemeter | ACEAND DATE OF DISPOSITION COMMITTEE OF THE PROPERTY OF THE PR | ME AND ADDRESS OF FA | 9-/7 | 50471 | H HAN | or Town, State |
| | 23. PART LEnter the disables, o | J Jav M | 100677 E | VANS CH | AFE. | RSI | ED. | MORIES PARKVILL |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) | e. List only one cause on each a. Auta da DUE TO (OR AS A CC | tec Bu | e mode of dying, sur | | | tory errest | Approximete Interval Betwoonsat and Do |
| ERTIFICATION | Sequentielly liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury that initiated evente resulting in deeth) LAST | b. DUE TO (OR AS A CC c. DUE TO (OR AS A CC | | | | | | |
| MEDICAL C | PART II. Other eignificant conditi | ons contributing to death but | not reculting in the unde | rlying ceuee given in | | 24a. WAS AN AI PERFORM 1 YES 2 | EO? | 24b. WERE AUTOPSY FINDI AWAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 APO |
| CIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | 28. PLACE OF DEATH (C | heck only one |) | | |
| ΥS | 1 VES 2 NO | HOSPITAL: 1 Inputiant 2 ER/Outputie | oTHER: | Home 5 Residence | 6 🗆 Other | (Specify) | | |
| ву РН | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | | INJURY M | c. INJURY AT WORK? YES 2 NO | | CRIBE HOW INJ | | |
| ETED | 3 Suicide S Could not to | building, etc. (Specify) | At home, farm, street, factory | опіса | | TION (Street and r Town, State) | 1 Number or F | Rural Route Number, |
| COMP | | YSICIAN: To the best of my knowled- INER: On the bests of examination at | | | | | | ause(a) and manner as state |
| O BE C | 296 SIGNATURE AND TITLE OF CERTIF | the 400 | | | 29c. LICENSE NUMBER 29d. D. 0 | | | PNED (Menth, Day, Year) |
|) | 30, NAME AND ADDRESS OF PERSON OF PE | WHO COMPLETED CAUSE OF DEATH | 1 (ITEM 27) (Type, Print) | | | | | |
| | 31. DATE SEP 07.791994 | 32. REGISTRAR'S SIGNATU | | | | | | |

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BALTIMORE, MARYLAND 21215-0020

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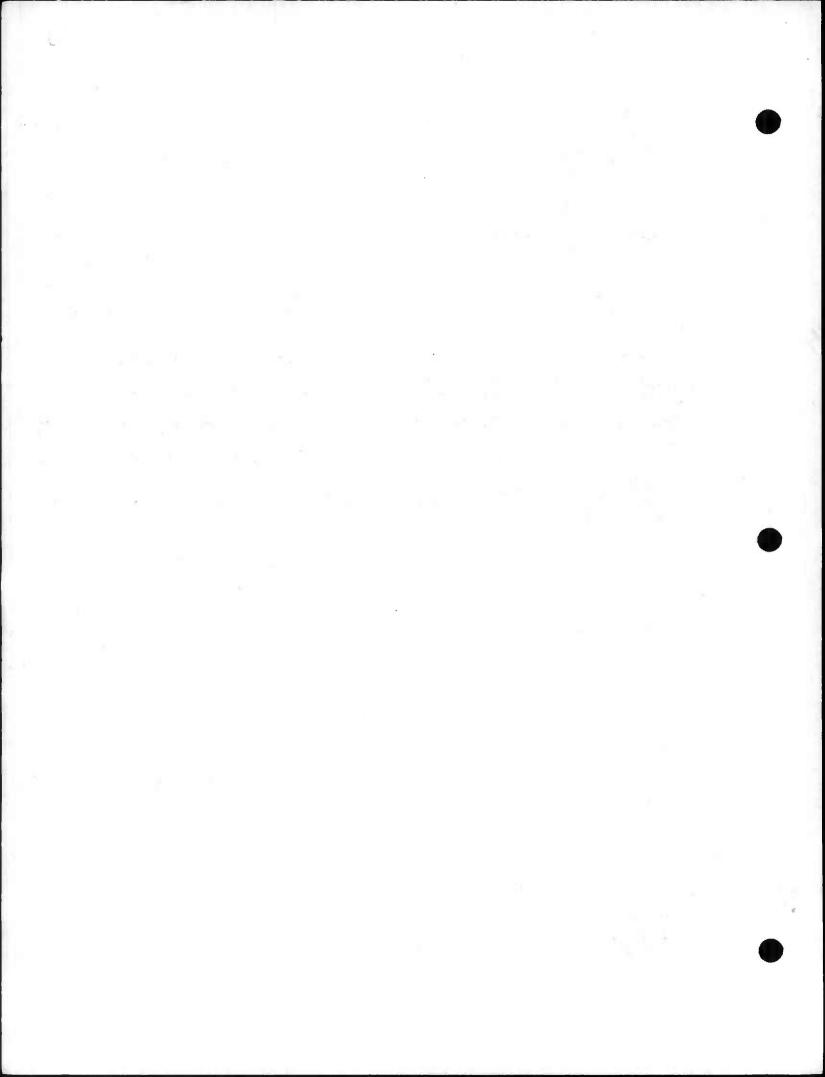
HOSPINL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an hours after death. Page 6 may be retained by the hospital or attending physician.

WERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defached for use as the burial-transit permit. Pages 1, 2, 3 should man 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

WERAL DIRECTOR: After this certificate has been signed by the attending physician.

FOR

| | - STATE REGISTRAR | | CERTIFIC | CATE OF | DEATH | REG | . NO. | | | |
|---------------|--|-----------------------------|-----------------------------|--------------------------------|--|------------------------------------|-----------------------|---------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | 2. DATE OF DEA | TH | WEAR | 3. TIME OF DEATH | |
| | SHELDON | m. | BREEC | { | | MONTH S - | 28- | 9 LJ | 1:15 PM | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AG | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRT (Month, Day, Ye | H | | PLACE (State or Foreign | |
| | 218-32-3854 | 1 M M 2 🗆 F | 60 YRS. | ONTHS DAYS | HOURS MIN. | | 4-34 | Country | WN. | |
| | 9e. FACILITY NAME (If not institution, give s | treet and number) | | B. CITY, TOWN C | R LOCATION OF DE | ATN | 9c. COI | UNTY OF D | EATH | |
| OR | FAILSTON GENR | AL HUSPITAZ | | FA | 11ston | | 1 | HARF | ues co. | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | | | | | | 1211-1 | | |
| <u> </u> | 100. STATE | - OCION | ^ | TOWN OR LOCAT | ION | | | | 10d. INSIDE CITY LIMITS? | |
| | 100. STREET AND NUMBER | GILTORD (| 0. 0 | TREE | | | | | 1 YES 2 NO | |
| FUNERAL | 2581 MILL | COSEN | Park | 101 | ZIP CODE | ./ | 10g. Cr | TIZEN OF W | HAT COUNTRY? | |
| ¥ | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | TUAL | 1 | 2/12 | 7 | | 1.0 | ./. | |
| | 1 Never Married 2 Merried | FORCES? 1 YE | S 2 NO | If yes, sp | ENDENT OF HISPAN city Cubpn, Mexico | n, Puerto Rican, et | ty Yea or No — c.) | | - African Indias, White, etc. | |
| B | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR | ARMY | 1 U YES | 2 AG Specify | <i>)</i> : | | Specif | H175 | |
| | 15. DECEDENT'S EDU | CATION | 16a. DECEDENT'S U | SUAL OCCUPATION | N . | 16b. KIND 0 | F BUSINESS/IN | | 11-17- | |
| Щ | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use | rk done during mo retired.) | of working | | | | | |
| 린 | 12 | | ZUT, | BALTI | MORE | CO. F. | RE. | DEF | 7. | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Lest) | h 22- | | | 18. MOTNER'S NA | ME (First, Middle, M | laiden Sumame) | | | |
| BE (| MYRON DAVIS | D BREE | CE | | 2015 | RU. | SSEL | 1 | | |
| 5 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING A | DDRESS (Street a | nd Number or Rural I | Route Number, City | or Town, State, Z | ip Code) | | |
| - | MARY JANE (NEE | TOWNSHENS | 9 3581 | MIL | GRE | EN K | MD, | STRI | ET, MO. | |
| | 20a. METNOD OF DISPOSITION 1 Burlel 2 Cremetton 3 Rem | | Ob. PLACE AND DATE OF | DISPOSITION (Na | me of | DATE 20 | c. LOCATION - | - City or To | wn, State | |
| | 4 Donation 5 Other (Specify) | | 41671112 | V mt | M. GAR | 2,9-01/ | TORFE | CA | co, MD. | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | - 41C | t | 22. NAME AN | D ADDRESS OF FA | CILITY | CH | rask | | |
| J. | 19 Then J. | Jan " | 2006-77 | 3/1/2 | 7.19007 | - NP | F. 0155 | THE | Um II | |
| | 23. PART I. Enter the diseases, or | mplications that cous | ed the deeth. Do no | t enter the mo | de of dying, suc | h as cardiec or | | | Approximate | |
| | shock, or heart fellure | List Dnly one cause on | each line. | | | | | | Interval Between Onset and Death | |
| | disease or condition | Wood & | Phoet I | denis | 1 | | | | Onset and Death | |
| | resulting in death) | DUE TO (OR A! | A CONSEQUENCE OF | June | | | | | | |
| z | C b. | | | | | | | | | |
| 임 | Sequentially list conditions, if any, leading to immediate | | | | | | | | | |
| 8 | cause. Enter UNDERLYING CAUSE (Disease or Injury | с. | | | | | | | | |
| | that initiated events | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | | | |
| CERTIFICATION | resulting in deeth) LAST | d | | | | | | | | |
| _ I | PART II. Other significent condition | e contributing to deeth | but not resulting in | the underlying | ceuse given in | Part I. 24s. W | AS AN AUTOPSY | 24h | WERE AUTOPSY FINDINGS | |
| DICA | | - 35 | - | | 14712 | PE | RFORMED? | 1 | MAILABLE PRIOR TO COMPLETION OF CAUSE | |
| | | | | | | 1 🗆 Y | ES 2 NO | | OF DEATN? | |
| 2 | DID TOBACCO USE O | CONTRIBUTE TO | CAUSE OF | DEATH Y | ES NO | | | | 1 WES 2 NO | |
| ₹ | 25. WAS CASE REFERRED TO MEDICAL | | | | ACE OF DEATH (Ch | | | | | |
| PHYSICIAN: ME | EXAMINER? | HOSPITAL: | | OTHER: | 5 Residence | | | | | |
| ¥ | 27. MANNER OF DEATN | 28a, DATE OF INJUR | Y 28b, TIME | OF 28c INJ | | 28d. DESCRIBE N | | CCURED | | |
| | 1 Natural 5 Pending | (Month, Day, Year 8-28- | 94 17-18 | M 1 U | ES 2 NO | 7000 | men. | n | alan | |
| BY | 2 Accident Investigation 3 Suicide S Could not be | 28e. PLACE OF INJU | RY — At home, farm, str | eet, factory, office | | 28f. LOCATION (S | | or or Rural R | oute Number, | |
| | 4 Homicide determined | building, etc. (S) | овспу) | | | RT 23 | M Math | 11/11 | nichila | |
| | 29a. CERTIFIER 1 CERTIFYING PHYSI | CIAN: To the best of my kno | owledge death occurred | et the time date | | 14000 | 100 | - | | |
| ¥ | | R: On the basis of examinat | | | | | | | and manner or stated | |
| COMPLETED | 29b. SJETPATURE AND TITLE OF CERTURIES | | -// | | | | | | | |
| 4 | AND THE AND THE OF CERTIFIER | 1 Sight | defamen | Pis. | 29c. LICENSE NUM | _ | 29d. DA | TE SIGNED | (Month, Day, Year) | |
| 2 | 30, NAME AND ADDRESS OF PERSON WIN | O COMPLETED CAUSE OF | DEATH (ITEM AT /E-) | wine) | OCM | | | 15- | | |
| | 30. NAME AND ADDRESS OF PERSON IN RICHARD J. CO | I COO MAT | νεα (п ви 27) (лура, Р Э | 2013 | TRAPPL | - CHURC | A KO | AD | o z il | |
| | 31. DATE FILED (Month) Denviner). | 32. REGISTRAR'S SIG | SNATURE | | DARLI | NGTON | MD | 2/0 | 178 | |
| | | John Danden- | | | | | | | | |



| | | FOR STATE REGISTRAR 1. OECEDENT'S NAME (First, Middle, Last) | STATE OF MARYL | CERTI | FICATE O | F DEATH | REG. | NO. | 3. TIME OF DEATH | | |
|--|---------------|--|---|-----------------------|---|-----------------------|---|----------------------|-------------------------------------|--|--|
| | | BARBAR | A BOA | TWI | रादमः | T | SEPT | DAY | 44 3:00 PM | | |
| P | | 4. SOCIAL SECURITY NUMBER 212 46 9123 | 1 □ M 2 16 F 78 | (In yrs. last birthda | MONTHS DAY | | 7. DATE OF BIRTH | 1916 | BIRTHPLACE (Sinte or Foreign | | |
| 2, 3 should | CTOR | | an Hospital | | | n or Location of I | DEATH | 9c. COUNT | Y OF DEATH | | |
| it. Pages 1, | DIREC | 10a. STATE 10b. COUNT Maryland Ba | ltimore | 10c. 0 | ESS | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | |
| n. ansit permit. | IERAL | 10. STREET AND NUMBER 355 Stillwat | er Rd. | | | 10f. ZIP CODE 2122 | 1 | 10g. CITIZE | N OF WHAT COUNTRY? | | |
| nding physician. | BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married Wildowed 4 Divorced | 12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D | 2 NO | | | | | | | |
| al or atte for use a | LETED | 15, DECEDENT'S EDU (Specify only highest grade Elementapy/Secondary (0-12) | CATION completed) College (1-4 or 5+) | Man bind | 'S USUAL OCCUP. If work done during use House | | 16b. KIND OI | BUSINESS/INDU | STRY | | |
| e 8 8 | COMPL | 17. FATHER'S NAME (First, Middle, Last) Henry Scha | efer | | | 18. MOTHER'S N | AME (First, Middle, Malden Sumame) ta Crosswell | | | | |
| retained to 5 should notified | TO BE | 19a. INFORMANT'S NAME (Type/Print) Lisa Bauer, Grand | | | | et and Number or Rura | Route Number, City o | r Town, State, Zip C | | | |
| e age | | Lisa Bauer, Grand Daughter 351 Stillwater Rd. Baltimore, MD 21221 20a. METHOD OF DISPOSITION 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Cardens of Faith Cemetery 9/3/94 Baltimore Co., M. | | | | | | | | | |
| death. | | 22 NAME AND ADDRESS OF FACILITY Bruzdzinski Funeral Home PA 1407 Eastern Ave. Balto., MD 21221 | | | | | | | | | |
| certificate be executed within indiging physician and completely filling physician and completely fillingiene prior to bunial, cremation, other traumatic event, the | CERTIFICATION | 23 AART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such se cardiac or respiratory errest, above, or heart failure. Liet only one cause on each line. IMMEDIATE CAUSE (Final disease or condition) resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | |
| law requires that the death as been signed by the atten bept. of Health and Merital P. 23 shows any Injury, or | MEDICAL | PART II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. CEREBROVASCULAR ACCIDENT 1 ves 2 140 Were Autopsy Find Completion of cause of the completion of cause of ca | | | | | | | | | |
| a se fe | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | patient 3 🗆 DOA | OTHER: | PLACE OF DEATH (C | | | | | |
| PHYSICI. this cert with the | PHY | 27. MANNER OF DEATH 1 Natural 5 Pending | 28s. DATE OF INJURY (Month, Day, Year) | 28b. T | IME OF 28c. | INJURY AT WORK? | 28d. DESCRIBE H | | RED | | |
| R ATTENDING PHYSICIAN: RECTOR: After this certifications after death with the St. Im 28 is marked, or it. | TED BY | 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined | 28s. PLACE OF INJURY building, atc. (Spe- | f — At home, larn | | T TES 2 NO | | | Rural Route Number, | | |
| No. | OWFLE | | CIAN: To the best of my know | | | | | | cause(s) and manner as stated. | | |
| D D S THE | 2 | 29b. SIGNATURE AND TITLE OF CERTIFIED | MEDICAL | REJID | ENT | 29c. LICENSE NU | IMBER 727 | 29d. DATE | SIGNED (Month, Day, Year) | | |
| , | 2 | 30. NAME AND ADDRESS/OF PERSON WH MOHAMMAD S | O COMPLETED CAUSE OF DE | 5601 | pe Print) | RAVEN | BLVD. E | BALTIM | ORE, MD Z1239 | | |
| | | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGN | | | | | | | | |

272 46 9123 x 76 Good Samtrean Hospital @Soniding argand baltimore X m-118.E 355 Dtallwater Rd. X 70 0,1 400 0

refresche wines

Alberta Crosswell Lass much Grand Deuriter 351 Stillwater Hd. imitimare, No. 21221

unreads of Fath Cemetery 9/3/94 Halthore Go., 15

21251

Wil smoth Largeur's historical 1407 Eastern ave. Helto., ND 21221

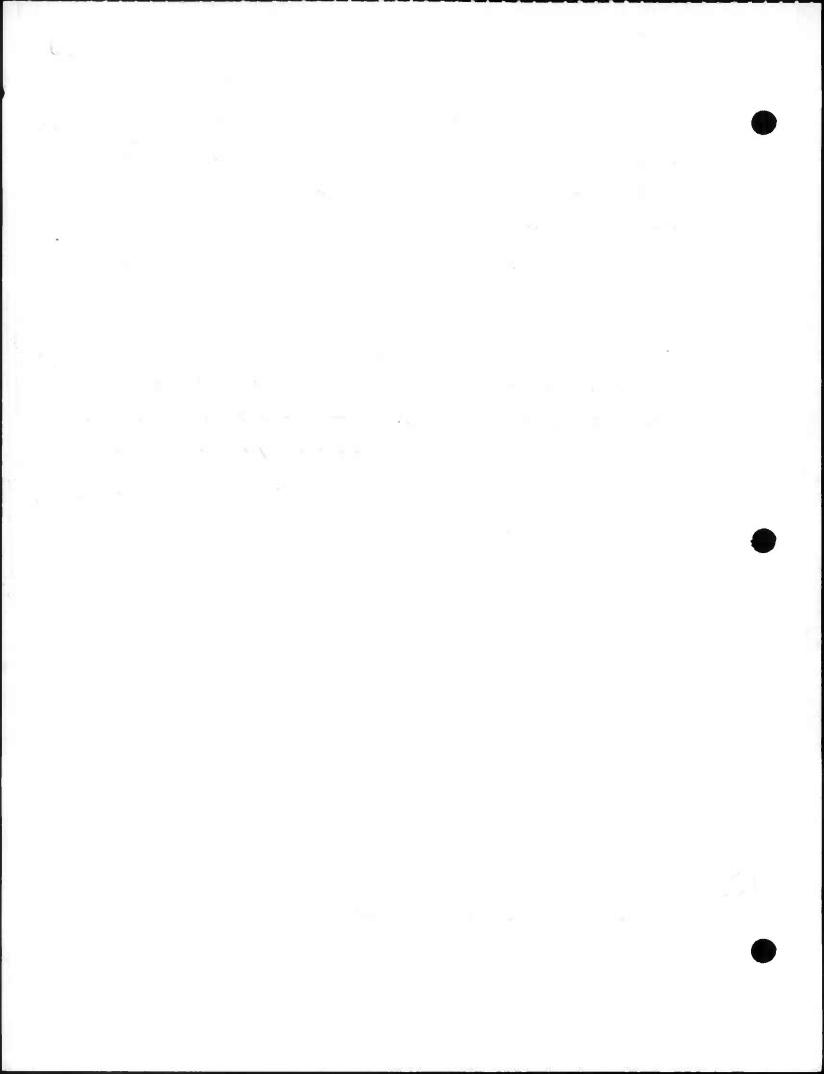
Suns 20, 1916 Fatyland

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rours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 INL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with DIVISION OF VITAL RECORDS, P.O. BOX 68760,

DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAI | ND / DEPARTM CERTIFIC | | | MENTAL HYGIEN REG. NO | | | |
|---------------|--|--|---|--|--------------------------------|---|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) ELISABETH JO | OHANNA BERCH | INER | | | 2. DATE OF DEATH September | "3, 199 | 3. TIME OF DEATH 4:10 P.M. M | |
| | 217-38-0792 | 1 □ M 2 💢 F 92 | YRS. MO | UNDER 1 YEAR NTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Sept. 4, | Co | ermany | |
| TOR | 9e. FACILITY NAME (If not institution, give street Holly Hill Manor RESIDENCE OF DECEDENT | et and number) | 91 | Towso | n Location of Di | EATH | Balt | imore | |
| DIRECTOR | 10a. STATE 10b. COUNTY | timore | 10c, CITY, T | OWN OR LOCAT | ON | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 🔯 NO | | |
| FUNERAL | 531 Stevenson I | | | | ZIP CODE 21204 | | 10g. CITIZEN OF WHAT COUNTRY? Germany | | |
| BY FU | 11. MARITAL STATUS 1 1 Nover Married 2 | | | ED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Ye If yea, specify Cuban, Maxican, Puerto Rican, atc.) 1 YES 2 NO Specify: | | | S S | ACE — American Indian, Black, White, atc. Specify: hite | |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade co | (Give kind of work life. Do NOT use re | CEDENT'S USUAL OCCUPATION Ive kind of work done during most of working Do NOT use retired.) | | | SINESS/INDUSTR | Y | | |
| COMP | Unknown 17. FATHER'S NAME (First, Middle, Last) Ernest W. Berch | nner | Secreta | ry | | ME (First, Middle, Melden ia Y. Fisch | | immeric | |
| TO BE | 19e. INFORMANT'S NAME (Type/Print) Mrs. LaVerne R. Ke | ernan | | | | Route Number, City or Tow | | | |
| | 20a. METHOD OF DISPOSITION 1 | rail from State cemete | LACE AND DATE OF DEPTY OF OTHER SE | rvice (| corp. 9/0 | 6/94 Tow | cation – city o son, Ma | | |
| | 23. PART I. Enter the diseases or co | Jary | | Ruck | Towson 1 | Funeral Ho | me, Inc | 1050 York Ro | |
| | ahock, or heart failure. Li iMMEDIATE CAUSE (Final disease or condition reaulting in death) a. | at only on cause on aac | h ilna. | enter the mor | e or dying, add | n aa carolac or respi | retory arreat, | Approximate interval Between Onset and Death | |
| CERTIFICATION | Sequantially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated evants reaulting in death) LAST | DUE TO (OR AS A C | ONSEQUENCE OF): | | | | | | |
| MEDICAL CI | PART II. Other algolificant conditions | contributing to death but | not reaulting in t | he undarlying | cauaa givan in | Part I. 24a, WAS AN PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| PHYSICIAN: ME | DID TOBACCO USE CONTRI | | DEATH YES | _ | UNCERTAIN | N D | | 1 YES 2 NO | |
| SIC | | HOSPITAL: Inpetient 2 ER/Outpeti | 0 | гнын: | 5 - Residence | 8 Other (Specify) | | | |
| ВУ РН | 27. MANNER OF DEATH 1 Naturel 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF | M 1 Y | | 28d. DESCRIBE HOW II | NJURY OCCURED | | |
| | 3 Suicide 8 Could not be determined | building, stc. (Specify) | JRY — At home, farm, streat, factory, office pocify) | | | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| COMPLETED | one) 2 MEDICAL EXAMINER: | AN: To the best of my knowled On the beels of exemination a | | | | | | se(s) and manner ea stated. | |
| 10 | 296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO | Carcli COMPLETED CAUSE OF DEAT | H (ITEM 27) (Type. Prir | nt) | DO 7 | 4 30 | 29d. DATE SIGN | NED (Month, Dey, Year) | |
| | Hans J. Koetter, I | | Osler D | | Towson, | Maryland S | uite 31 | 5 | |



IRS. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should lier death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. ours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760, ENDING PHYSICIAN: The law requires that the death certificate be executed with

28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | REGISTRAR | CERTIFIC | CATE OF DEATH | REG. NO. | | | | |
|------------------|--|--|--|------------------------------------|--|--|--|--|
| | 1. DECEOENT'S NAME (First, Middle, Last) | | | 2. DATE OF OEATH | 3. TIME OF DEATH | | | |
| | Dewey Floyd BRA | NHAM | | Sep. 4, 1 | 994 12:01 A M | | | |
| | | AGE (In yrs. last birthday) | IF UNDER 1 YEAR | 7. DATE OF BIRTH | 8. BIRTHPLACE (State or Foreign | | | |
| - | × | | IONTHS DAYS HOURS MIN. | (Month, Day, Year) | Country) | | | |
| | 214-14-1225 1 LM M 2 F F 9a. FACILITY NAME (if not institution, give street and number) | 19 | | | Virginia | | | |
| or I | - 10 0000 | | 9b. CITY, TOWN OR LOCATION OF D | EATH 9c. COL | UNTY OF DEATH | | | |
| FUNERAL DIRECTOR | Frederick Villa Nursing Ce | nter | Catonsville Baltimore Cou | | | | | |
| <u>[</u> | 10a, STATE 10b, COUNTY | 10c CITY | TOWN OR LOCATION | | | | | |
| <u>E</u> | Maryland Baltimore Count | v Ar | butus | | 10d. INSIDE CITY LIMITS? | | | |
| 9 | | 7 | | | 1 TYES 2 NO | | | |
| M | 10e. STREET AND NUMBER | | 10f. ZIP CODE | 10g. Cl | TIZEN OF WHAT COUNTRY? | | | |
| 当し | 1247 Locust Avenue | | 21227 | U | . S. A. | | | |
| 5 | 11. MARITAL STATUS 12. WAS DECEDENT E FORCES? 1 | VER IN U.S. ARMED | | NIC ORIGIN? (Specify Yes or No- | 14. RACE — American Indian, | | | |
| | IE VES CIVE WAD | OR DATES | If yes, specify Cuban, Maxico 1 YES 2 NO Specific | | Black, White, atc. Specify: | | | |
| ВУ | 3 Widowed 4 Divorced World War | II | | | White | | | |
| | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 16a. DECEDENT'S U | SUAL OCCUPATION rk done during most of working | 16b. KIND OF BUSINESS/IN | DUSTRY | | | |
| 画 | Elementary/Secondary (0-12) Coflege (1-4 or 5+) | life. Do NOT use | retired.) | | | | | |
| 뢰 | 6 | Heavy Eq | uipment Operato | r Steel Man | ufacturing | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | 3.7 24 | | ME (First, Middle, Maiden Surname) | | | | |
| | | RANHAM | Minnie | | JOHNS | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | | | | | | |
| 임 | | | DORESS (Street and Number or Rural | | | | | |
| | Mary L. Branham | | | Baltimore, MD | 21227 | | | |
| | 20a. METHOD OF DISPOSITION 1 General 2 Cremation 3 Removal from State | 20b. PLACE AND DATE OF | DISPOSITION (Name of | OATE 20c. LOCATION - | - City or Town, Stata | | | |
| | 4 Donation 5 Other (Specify) | Meadowridg | e Memorial Park | 9/7/94 Elkridg | e, MD | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF FA | CILITY | | | | |
| | > M Thelles | .) | | ral Home, Inc. | | | | |
| - | 23. PART I. Enter the diseees, or complications that co | | 410/ Wilkens | Avenue Balti | more, MD 21229 | | | |
| | shock, Dr heert fallure. List only one cause on each line. Interval Between Onset and Death disease or condition resulting in desth) Due to for As A Consequence of State of | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reculting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| ا د | PART II. Other significent conditions contributing to dec | eth but not resulting in | the underiving cause given in | Part I. 24e. WAS AN AUTOPSY | 24b. WERE AUTOPSY FINDINGS | | | |
| EDICAL | 1 HR | | , | PERFORMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | |
| | - A | | | 1 TYES 2 HO | OF DEATH? | | | |
| Σ | | | | | 1 TYES 2 NO | | | |
| ÿ∥ | DID TOBACCO USE CONTRIBUTE TO CAUS | E OF DEATH YES | □ NO □ UNCERTAI | V 🗆 | | | | |
| 5 1 | 25. WAS CASE REFERENCE TO MEDICAL EXAMINENT | 26. PLACE OF OEATH | | | | | | |
| اً قَ | 1 YES 2 NO 1 Inpution 2 ER | | OTHER: Mursing Home 5 - Residence | 6 Other (Specify) | | | | |
| PHYSICIAN: | 27. MANNER OF OEATH 26e. OATE OF INJ | URY 26b. TIME | OF 28c. INJURY AT | 26d. DESCRIBE HOW INJURY OF | CCURED | | | |
| - 4 | 1 Natural 5 Pending (Month, Day,) | (her) | WORK? M 1 YES 2 NO | no are named to the artists. | | | | |
| à l | 2 Accident Investigation 3 Suicide & Could not be 26e. PLACE OF IN | JURY — At home, ferm, str | | 26f. LOCATION (Street and Number | | | | |
| 급 | 4 Homicide Could not be building, etc. | (Specify) | set, lectory, diffee | City or Town, State) | r or Hural Ploute Number, | | | |
| <u></u> | | | | | | | | |
| 뢰 | 29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my | knowledge, death occurred | at the time, data and place, and due | to the cause(s) and menner es sta | nted. | | | |
| COMPLETED | one) 2 MEDICAL EXAMINER: On the besis of exami | nation and/or investigation, | in my opinion, death occured at the | time, date and piece, and due to t | he cause(s) and manner as stated. | | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUI | | | | | |
| H | 12 2 | In | | 29d. DAT | TE SIGNED (Month, Day, Year) | | | |
| 0 1/1/28/1 | | | | | | | | |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF David R. Moseman, M.D. 52 | of death (Item 27) (Type, P 05 East Dri | | MD 21227 | | | | |
| | 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S | SIGNATURE | | | | | | |
| | SEP 0 7 1994 A | -Ro. 2008 | | | | | | |

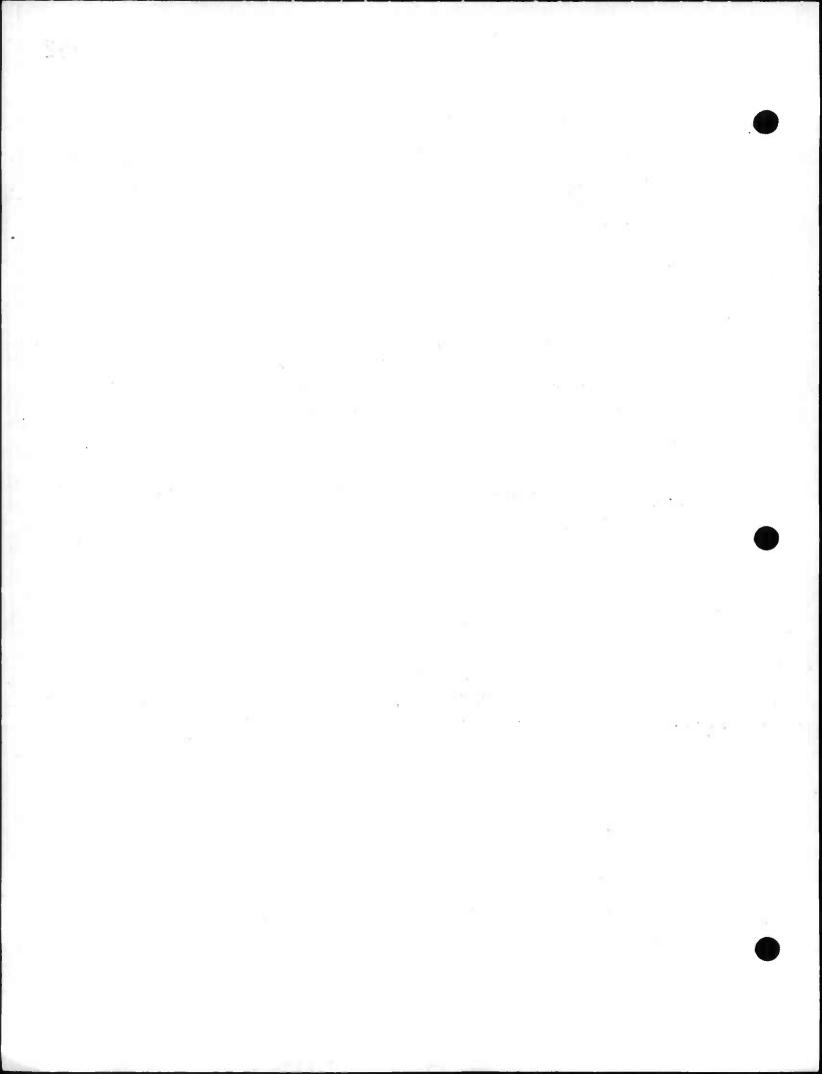
3+1

ft. DIVISION OF VITAL RECORDS, P.O. BOX 68760

| | FOR STATE REGISTRAR | STATE DF MARYL | AND / DEPARTM CERTIFIC | | | MENTAL HYGIEN | Ε | | | | |
|-------------------------|--|---|--|--|--------------------------------|--|------------------|------------------------|---|-----------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) VINCENT J. | BOCIANOWSK | I | | | 2. DATE OF DEATH | w 31 | YEAR 94 | 3. TIME OF DEATH | м | |
| | 010 00 0000 | 5. SEX 6. AGE (1 | | ONDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH 0.5 - 14 - 20 | | 8. BIRTHE Country, MAR | YLAND | | |
| OR | 98. FACILITY NAME (If not institution, give stree FRANKLIN SQUARE | | 96 | CITY, TOWN C | R LOCATION OF DI | EATH | 9c. COUN | TY OF DE | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10c. CITY, TO | OWN OR LOCAT | ION | | | | 10d. INSIDE CITY LIMITS? | \exists | |
| AL DI | MARYLAND 100. STREET AND NUMBER | | | 101 | . ZIP CODE | | 1 _ YES 2 _ NO | | | \dashv | |
| FUNERAL | 9405 ARMADA WAY | | | | | | I | JSA | | | |
| B | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARM FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES WWILL | | | | | | | | or No — 14. RACE — American Indian, Black, White, atc. WMTTE | | |
| TE | 15. DECEDENT'S EDUCA (Specify only highest grade of | completed) | 16a. DECEDENT'S USL (Give kind of work life. Do NOT use re | done during mo | ON st of working | 16b. KIND OF BUS | SINESS/IND | USTRY | | \neg | |
| COMPLETED | 12 YEARS | College (1-4 or 5+) | COOL MAK | | | MARTIN | | LETT | CA_ | | |
| BE CO | 17. FATHER'S NAME (First, Middle, Last) PAUL BOCIANOWSK | i | | | 18. MOTHER'S NA JOSEPH | ME (First, Middle, Maiden INE MAH) | Sumame) LAKEV | WICZ | | | |
| 0 | MRS. HELEN BOCI | ANOWSKI | 9405 AI | RMADA | MAY | Route Number, City or Tow | n, State, Zip | Code) | | | |
| | 26a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Ramon 4 Donation 5 Other (Specify) | | PLACE AND DATE OF D | | | 19-3 BAL | ro C | Ity or Tow | MD . | | |
| | 2) SIGNATURE OF FUNERAL SERVICE LICE | aurusii. | , | | | FUNERAL K AVENUE | | | MD. 212 | 22 | |
| CERTIFICATION | ahock, or heart failure. L. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A | | Coron | aryan | tery Desia | Al | | Interval Betwee | | |
| BY PHYSICIAN: MEDICAL C | | contributing to deeth be fibruled a manife | Cen | ne underlyln | g cause given in | Part I. 24a. WAS AN PERFOR | MED? | | WERE AUTOPSY FINDING AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| ICIA | | HOSPITAL: | on | 28. PL | ACE OF DEATH (Ch | eck anly one) | | | | | |
| HYS | 1 YES 2 NO 27. MANNER OF DEATH | 1 Inputiant 2 ER/Outp | 28b. TIME OI | 28c. INJ | URY AT | 8 Other (Specify) 26d. DESCRIBE HOW II | NJURY OCC | URED | | \dashv | |
| 8Y F | 1 Netural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJURY | M 1 🗆 1 | RK? /ES 2 NO | | | | | | |
| ETED | 3 Suicide 6 Could not be 4 Homicide detarmined | building, atc. (Spec | — At home, farm, stree | ne, farm, street, factory, offica 28f. LOCATION (Street City or Yown, State) | | | and Number | or Rural Ro | oute Number, | | |
| COMPLETED | | IAN: To the best of my knowl : On the basis of exemination | | | | | | | and manner as stated | | |
| BE (| 296. SIGNATURE AND TITLE OF CERTIFIER | | | 29c. LICENSE NUI | | | | (Month, Day, Year) | \exists | | |
| ٥ | 30. NAME AND ADDRESS OF PERSON WHO | met | _ | 1) | 1210 | | / | -29 | 7 | \dashv | |
| | 31. DATE FILED (Month, Day, Year) | 1 32. REGISTRAR'S SIGN | ATURE | T DA | uto pi | 021234 | | - | | - | |
| | SEP 0 7 1994 | Tapi Sanian-Ra | بالملياب | | | | | | | | |



TO THE HOSPITA TO THE BRANCH DE BOOK

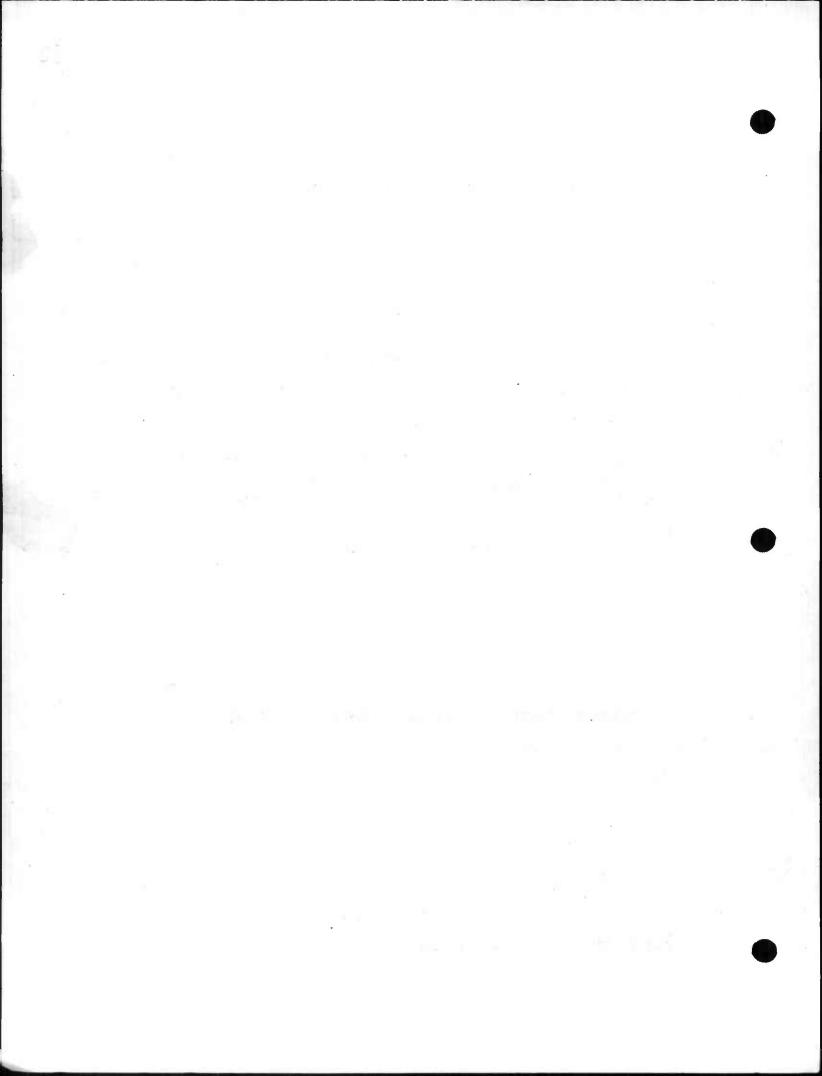


ay be retained by the hospital or attending physician. page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

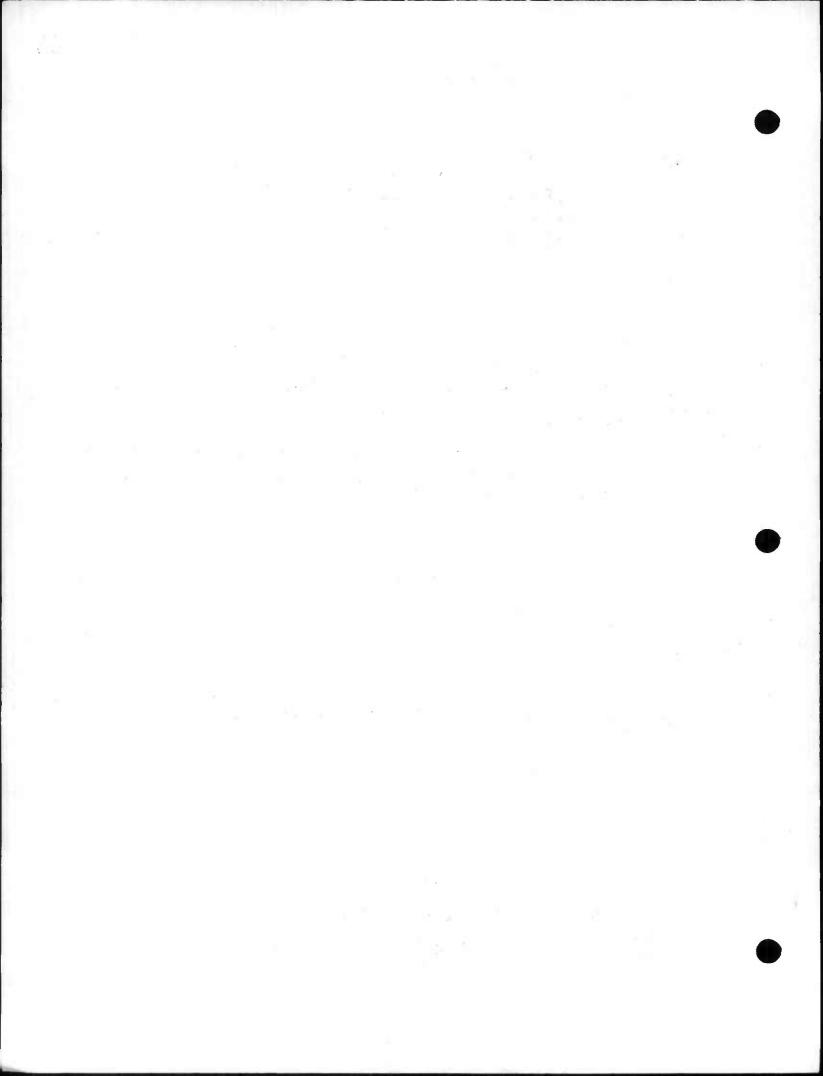
| | he hos | detache | | once. |
|---|--|---|--|--|
| | 5 | 2 | | Te |
| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within cours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache | | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| | be | ge 5 | | 6 3 |
| | may | 8. | | st |
| | 9 9 | recto | | Ē |
| | Pag | al di | | iner |
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| | se dea | the at | Ment | ilary, |
| | nat th | 2 | and | ly in |
| | t sa | gned | earth | \$ 31 |
| | equir | BN Si | 04 H | how |
| | J ME | s be | ept. | 23 8 |
| | The | ate ha | be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | tem ? |
| | SIAN | rtific | he Si | 0r 1 |
| | -WSI | iis ce | ith ti | ed, |
| | NG PP | ter th | ath w | mark |
| | NO | R. Al | er de | .00 |
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| | 8 | DIR | hour | iterr |
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| | 5 | 10 | be fi | 볼 |
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| | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | | | HEALTH AND F DEATH | MENTA | L HYGIEN | E | | | | |
|------------------|--|---|-----------------------------------|---|---|---------------------------|---------------------------------|-------------------|-----------------------|---------------------------------|----------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH 3. TIME OF DEATH | | | | | TH | | | | |
| | WANDA L. B | BASHAM | SHAM I | | | | | | SEPTEMBER 1 1994 2:35 | | | |
| | A HE TOOL A SECTION | . SEX 6. AGE (II | IF UNDER 24 HRS. | 7. DATE OF BIRTH S. BIRTHP | | | | PLACE (State or I | Foreign | | | |
| | BB 1 17 0003 | □ M 2 X F 3 | HOURS MIN. | | 2, 19 | 62 | Vir | ginia | | | | |
| œ | 9a. FACILITY NAME (If not institution, give street THE JOHNS HODVING | | | | CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | |
| DIRECTOR | THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY | | | | | | | | | | | |
| 3EC | 10a. STATE 10b. COUNTY | | 10c. CITY | , TOWN OR LOC | ATION | | | | | 10d. INSIDE CIT | γ | |
| | Virginia | | Roa | noke | | LIMITS? 1 X YES 2 NO | | | NO | | | |
| 3AL | 10e. STREET AND NUMBER | | | | IOI. ZIP CODE | P CODE 10g. CITIZEN OF WI | | | | | | |
| FUNERAL | 1406 Orange Ave. N | | | | 24017 | | | | | | | |
| F | 11. MARITAL STATUS 1 Never Merried 2 Married | P. WAS DECEDENT EVER IN FORCES? 1 YES | 2 X NO | 13. WAS D | ECENDENT OF HISPA specify Cuban, Maxic | NIC ORIGII an, Puerto | N? (Specify Yea Rican, etc.) | or No- 1 | 4. RACE Black | — American Ind , White, atc. | len, | |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DA | TES | 1 🗆 Yı | ES 2 X NO Spec | lty: | | | Specif | Black | | |
| COMPLETED | 15. DECEDENT'S EDUCAT (Specify only highest grade cor | ION moleted) | 16a. DECEDENT'S | USUAL OCCUPA | FION | 168 | . KIND OF BUS | INESS/INDU | STRY | | | |
| 91 | | College (1-4 or 5+) | life. Do NOT us | e retired.) | | | | | | | | |
| MP | | 3 | Admissi | ons Cl | | | | | ommu | nity Co | 1. | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S N | | | | | | | |
| BE | Aqustus Walter Jo 19a. INFORMANT'S NAME (Type/Print) | rdan | 105 MAII INC | ADDRESS (Com. | Barbar | | | | | | | |
| 2 | Paula Basham | | | | Ave.NW, | | | | | | - 1 | |
| | 20a, METHOD OF DISPOSITION | 20b. | PLACE AND DATE O | E DISPOSITION | Name of | ROOTE | | A 240 CATION — CI | | wn. State | | |
| | 1 Duriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Williams Memorial Park Roanoke, VA | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | SEE | | 22. NAME | AND ADDRESS OF F | ACILITY | | | | • | | |
| | * K. Seny (| lthe | | | NBURG FUN Harford | | | | MD | 21214 | | |
| | 23 PART i. Enter the diseases, or con | plications that ceused | the deeth. Do n | ot anter the n | node of dying, su | ch sa cen | diac or reapi | ratory erres | Bt, | Approxim | | |
| | ahock, pr hash fallura. List only one cause on each line. IMPEDIATE CAUSE (Final | | | | | | | | | | | |
| | disease or condition resulting in death) . Metastatic Adenocarcinima (prehalic ovenian) Dx 3 months | | | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| ON | Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| SAT | csuse. Enter UNDERLYING | | | | | | | | | | | |
| Ĕ | CAUSE (Disease or injury that initiated avants | DUE TO (OR AS A | CONSEQUENCE OF |): | | | | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | | | |
| AL C | PART II. Other aigniticant conditions of | ontributing to death bu | it not resulting l | n the underly | ng cause givan Ir | Part i. | 24s. WAS AN | AUTOPSY | 24b. | WERE AUTOPSY | FINDINGS | |
| 2 | | | | | | | PERFOR | | | AVAILABLE PRIOR | | |
| AE I | | | | | | | 1 1 163 2 | NO | | OF DEATH? | NO | |
| ž | DID_TOBACCO_USE_C | ONTRIBUTE TO | CAUSE OF | DEATH | YES N | O X | | | | | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | QSPITAL: | | 28. OTHER: | PLACE OF DEATH (C | | ne) | | | | | |
| YSI | | Inpetiant 2 - ER/Outpa | | 4 - Nursing He | ome 5 - Residence | 6 🗆 Othe | r (Specify) | | | | | |
| | 1 Natural 5 Pending | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME | JRY \ | NJURY AT YORK? YES 2 NO | 28d. DE | SCRIBE HOW IF | NJURY OCCU | RED | | | |
| 84 | 2 Accident Investigation 3 Suicide & Could not be | 28s. PLACE OF INJURY | – Al home, farm, s | | | 281.100 | ATION (Street a | and Number or | Pueni D | nuta Number | | |
| | 4 Homicide 8 Could not be | building, etc. (Special | (y) | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | or Town, State) | | | | | |
| COMPLETED | 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIA | N: To the best of my knowle | doe, death occurre | d at the time de | te and place, and du | a to the car | use(s) and man | nor on stated | | | | |
| MO | (Check only one) 2 MEDICAL EXAMINER: (| | | | | | | | | and manner as | stated. | |
| | 296. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NU | | | | | (Month, Day, Year | | |
|) BE | Afelt Xa | Oncelegy | Tellan | | M578 | | | 1 8 | 91 | 1/94 | | |
| 임 | 30. NAME AND ADDRESS OF PERSON WHO C | OMPLETED CAUSE OF DEA | TH (ITEM 27) (Type, | Print) | | | | | | 12.12 | | |
| | | nedley Coter | | chris Ha | him Heint | 41 | Beltin | 10c MI | ns. | | | |
| | SEP 0 7 1994 | 32. REGISTRAR'S SIGNA | TURE | | | | | | | | | |
| | SEF U 1 1334 Ju | i Dendem-Ran | leel. | | | | | | | | | |



DNMN-16 Rev 1/89

CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last 2. DATE OF DEATH 3. TIME OF OEATH 1:30 P 9 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTNPLACE (State or Foreign PENNSY/VANIA 91 YRS permit. Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Ag FUNERAL DIRECTOR TIMORE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BA MARYLAND MORE 1 PYES 2 NO 10e. STREET AND NUM 101. ZIP CODE 0g. CITIZEN OF WHAT COUNTRY? 2 director, page 5 should be detached for use as the burial-transit 02 INGS 2 le retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No-14. RACE RACE — American Indien, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Merri If yes, specify Cuben, Mexican, Puerto Ricen, etc.) IF YES, GIVE WAR OR DATES B Specify: 3 Widowed 4 Divorced White COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Spe College (1-4 or 5+) Welder once. 17. FATNER'S NAME (First, Middle, Lest) BARTKUS te e 9 BE notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Stre 2 CONCII SON hours after death. Page 6 may be Pe 20a. METNOD OF DISPOSITION 1 Buriel 2 ☐ Cremation 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must 4 Donetion 5 Other (Specify) the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE funeral 1/ 100 dA completely filled in by the cremation, or removal. 23. PART i. Enter the diseases, or complications hat coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one intarvsi Between IMMEDIATE CAUSE (Final Onsat and Daath disease or condition reaulting in death) Respiratory
DUE TO (OR AS A CONSCOURNESS F) other traumatic event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 OF ITTENDING PHYSICIAN: The law requires that the death certificate be executed with signed by the attending physician and com-Health and Mental Hygiene prior to burial, umoma CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING DIE TO (OR AS A QUISEOUENCE OF) CAUSE (Disease or injury that initiated eventa resulting in death) LAST 0 PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS 23 shows any i AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO been ō PHYSICIAN: Dept DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🛛 certificate has the the State Dept 25. WAS CASE REFERRED TO MEDICAL Item , 26. PLACE OF DEATN (Check only one) **EXAMINER?** OTHER 1 YES 2 NO 1 Inpatient 2 - ER/Outpatient 3 - DOA ne 5 🗆 Residence 6 🗆 Other (Specify) 0 27. MANNER OF DEATN 28e. DATE OF INJURY this c 28 is marked, 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 🔀 Natural 1 YES 2 NO В death Investigation After 2 Accident 3 Suicide 28e. PLACE OF INJURY — At homa, farm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Nomicide TO THE HOPPING OFFICE TO THE FLANEAU OFFICE DE filed within them 21 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my desth occurred at the time, date end place, end due to the cause(s) end manner as stated. 2 MEDICAL EXAMINER: On the ion, death occured at the time, data end placa, and dua to the cause(s) end menner as stated 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day. BE 9 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Qureshi M8900 Ave Baltun, CATON ì Ya 31. DATE FILEO (Month, Day, Year)
SEP 0 / 1994 32. REGISTRAR'S SIGNATURE i Danison-R



ITEMS: 23 PART I, 27, PER MEO FILM G-715 9/26/94 t.t.

| | _ | 1 - STATE REGISTRAR | STATE OF MA | ARYLAND C | / DEPAR | RTMENT OF ICATE OI | HEALTH A | ND MENT 1 | AL HYGIE REG. N | | | |
|---|---------------|--|---|-------------------|---------------|--|---|----------------|-------------------------------------|-----------------------------|-------------------------------|--|
| | 8 | 1. DECEDENT'S NAME (First, Middle, Last) SHAINYRA | | | | BROOKS | | 2. DA | TE OF DEATH | 31 1 | Q (54) | 3. TIME OF DEATH 10:00 A |
| | 1 5 | 4. SOCIAL SECURITY NUMBER | 5. SEX (| S. AGE (In yrs. I | | IF UNDER 1 YEAR | IF UNDER 24 | HRS. 7. DA | TE OF BIRTH | 21 1 | 8. BIRTHI | PLACE (State or Foreign |
| P | | , | 1 □ M 2 🗶 F | | YRS. | MONTHS DAYS | HOURS | MIN. 08 | onth, Day, Year) | 94 | Mary | vland |
| 3 should | œ | 9a. FACILITY NAME (If not institution, give : JOHNS HOPKINS | | Т | | 96. CITY, TOWN | OR LOCATION LTIMO | | | 9c. CO | UNTY OF DE | |
| 1, 2, | CTO | RESIDENCE OF DECEDENT | | <u></u> | | | | NE . | | | | |
| permit. Pages | DIRECTOR | 106. STATE 106. COUNT | · | | 10c. CIT | y, town or Loc Baltin | CCRES | 'i tar | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| permit | | 10e. STREET AND NUMBER | | | | | 01. ZIP CODE | лгу | | 10g. Cl | | HAT COUNTRY? |
| nsrt | FUNERAL | 1709 N. Dalla | | | | | | 231 | | | USA | |
| 21215-0020 al or attending physician. for use as the burial-transit | B≺ | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT FORCES? 1 I IF YES, GIVE WAR | YES 2 2 | RMED 3NO | It yes, i | CENDENT OF P pecify Cuban, R S 2 X NO | Mexicen, Puerl | GIN? (Specify) to Rican, atc.) | es or No- | 14. RACE Black, Specify | - American Indian, White, atc. |
| | LETED | 15. OECEDENT'S EDL (Specify only highest grade Elementary/Secondary (0-12) | | (| | USUAL OCCUPAT work done during in se retired.) | | 1 | 6b. KIND OF B | USINESS/IN | IDUSTRY | |
| LAND 2 the hospital detached to | COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | | | Lie MOTUES | NO NAME (C) | | | | |
| S P P | 1.1 | Wendell Brooks | | | | | | | t, Middle, Maid a Cur | , | | |
| MARYLAND retained by the hospit should be detached notified at once. | TO B | 19a. INFORMANT'S NAME (Type/Print) Ceresa Curtis | | ı | | ADDRESS (Street | and Number or | Rural Route No | imber, City or To | wn, State, Z | | |
| ORE, I 6 may be ctor, page t | 1 1 | 20a. METHOD OF DISPOSITION | | 20b.PLACI | E AND DATE | N. Dal | vame of | | MD ATE 20c. I | | - City or Tow | vn, State |
| Page 6 may all director, p | | 1X Puriel 2 Cremation 3 Ram 4 Donation 5 Other (Specify) | | Mour | remetory or o | on Cen | | | /94 La | andso | downe | e, MD |
| ALT death. funera | | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | | | Unit | y Fun | eral | | a R | 21+o | , MD 21201 |
| OX 68760, e be executed within 24 hours after e be executed within 24 hours after every filled in by the hinor to burial, cremation, or removal fraumatic event, the medical | | 23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | a. SUDDEN I DUE TO (O | on aach IIr | EATH S | YNDROME F): | oda of dying | , such as co | ardiac or res | piratory a | rrest, | Approximate interval Between Onset and Death |
| P.O. B th certifical ending phy I Hygiene p | CERTIFICATION | CAUSE (Disease or Injury that initiated evants resulting in death) LAST | DUE TO (O | R AS A CONSI | EOUENCE O | F): | | | | | | |
| RECORD; requires that the een signed by the of Health and M shows any Inju | : MEDICAL | PART II. Other significant condition | | | | | | | | N AUTOPSY ORMED? 2 NO | | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| TAL I | IAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | TH (Check only one | | RTAIN 🗆 | 1 | | | |
| VIT CIAN: T Strifficate he State | PHYSICIAN: | 1 X YES 2 □ NO | HOSPITAL: | | 3 🗆 DOA | OTHER: 4 Nursing Ho | me 5 🗆 Raside | ence 8 🗆 Ot | her (Specify) | | | |
| IN OF VI. ING PHYSICIAN- uter this certifica eath with the St marked, or It | ВУ РН | 27. MANNER OF DEATH 1 X Natural 5 Pending 2 Accident Investigation | 28a. DATE OF IN (Month, Day, | Year) | | M 1 | JURY AT ORK? YES 2 N | 10 | ESCRIBE HOW | | | |
| DIVISION OR ATTENDING DIRECTOR: After hours after death item 28 is ma | ETED | 3 Suicide 8 Could not be 4 Homicide determined | building, at | c. (Specify) | iome, tarm, | street, fectory, off | ce | | DCATION (Street by or Town, Stat | | er or Rural Ro | oute Number, |
| # 2 F F | COMPL | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYS. 2 XMEDICAL EXAMINE | CIAN: To the best of m | | | | | | | | | and manner as stated. |
| TO THE HOSPITA TO THE FUNERA De filed within 7 | TO BE | AND TITLED OF | Soll & | | | | O . C | M.E. | | | | Month, Day, Well) 01,1994 |
| | | 31. DATE FILED (Month, Day, Year) | O COMPLETED CAISE | M) 11 | 1 Pe | nn Str | eet, | Balti | more, | Mar | ylan | d 21201 |
| | | SEP 0 7 1994 | 12. REGISTRAM | LAN AND | والعا | | | | | | | |

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760 THIDING PHYSICIAN: The law requires that the death certificate be executed within

| | | REGISTRAR | | CERTI | FICATE O | - DEATH | REG. NO | | |
|--|---------------|---|----------------------------------|--|--------------------------------|-----------------------|-------------------------------------|--|---|
| | 8 | t. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH MONTH DA | AY YEA | 3. TIME OF DEATN |
| | - 8 | Walter C. E | rewster S | Sr. | | | 9 3 | | 8:05 P.M. |
| | | 4. SOCIAL SECURITY NUMBER | T | . AGE (In yrs. last birthday |) IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. 81 | RTHPLACE (State or Foreign |
| | - 8 | 235-36-7619 | t gg M 2 □ F | 66 YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) 8/14/28 | | ountry) |
| Divid | 1 1 | 9e. FACILITY NAME (If not institution, give | street and number) | | 9b. CITY, TOWN | OR LOCATION OF DE | | ac COUNTY O | st Virginia |
| 3 should | 2 | 102 North Charte | w Done Am | a. r | | | | | |
| . 2, | 일 | 102 North Charte | I ROAU AC | ot E. | Gren | Burnie | | Anne | Arunde1 |
| Se | DIRECTOR | 10a. STATE 10b. COUNT | TY. | 10c. 0 | TY, TOWN OR LOC | ATION | | | 10d. INSIDE CITY |
| T. | 洁 | Maryland Anne | _ Arundel | | on Draw | | | | t YES ZY NO |
| im. | ايا | 10e. STREET AND NUMBER | Arunoel | | en Burn | ICE IOF. ZIP CODE | | 10g, CITIZEN C | OF WHAT COUNTRY? |
| physician. burlal-transit permit. Pages 1, | FUNERAL | 102 North Charte | r Poad Ac | + F | | 21061 | | U.S. | |
| cian. | ΙŽΙ | 11. MARITAL STATUS | 12. WAS DECEDENT E | | 112 WMS 0 | | IIC ORIGIN? (Specify Yes | 1 | ACE American Indian, |
| ohysid | | 1 Never Merried 2 Merried | FORCES? 1 X | YES 2 NO | If yes, | specify Cuben, Mexica | n, Puerto Rican, atc.) | 6 | llack, White, etc. |
| as the t | B | 3 Widowed 4 Divorced | Korea & V | Manual Man | 1 U Y | ES 2 NO Specify | r: | s | White |
| tend as | | 15. DECEDENT'S EDI | | | S USUAL OCCUPA | TION | 16b. KIND OF BUS | SINESS/INDUSTS | ν |
| al or atte | | (Specify only highest grad | | (Give kind e | work done during use retired.) | nost of working | | J. 1. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. | |
| pital od fo | 12 | Elementary/Secondary (0-12) 12th Grade | College (1-4 or 5+) | Cold | | | Timita | d Chala | |
| the hospit detached once. | COMPL | 17. FATHER'S NAME (First, Middle, Last) | | Sold | rer | Tas morrison va | | d State | s Army |
| by the | | | ewster | | | The second second | ME (First, Middle, Maiden T C1 2333 | | |
| | B | ROCCIT A. BI 190. INFORMANT'S NAME (Type/Print) | CMPCET | | | | L. Slavy | | |
| 5 should | 임 | | | | | | Poute Number, City or Tow | | 21061 |
| y be rage 5 | | Katharina Brews | ter | 1 | | | d Apt E. G | | |
| e 6 may ector, pa must I | | 20e. METHOD OF DISPOSITION 1 tyr Burlel 2 Cremetion 3 Ren | noval from State | 20b. PLACE AND DAT cemetery, crematory of | | Name of | DATE 20c. LO | CATION - City o | r Town, State |
| ge 6 irect | | 4 Donetion 5 Other (Specify) | | Maryland | | ns Cem. | 9/6 Cro | wnsvill | e, Md |
| death. Page 6 may be funeral director, page I. examiner must be | | 21. SIGNATURE OF FUNERAL SERVICE L | | | 22. NAME | AND ADDRESS OF FA | Gonce | Funera1 | Home |
| fun fun Exam | | Lukara | 161 | Pares | 4001 | Ritchie | Hgwy Balti | | |
| n by the removal. | \vdash | 23. PART i. Entar the diseesea, or | | | | | | | Approximata |
| d in by th or remove | | ahock, or heert fellure. | Liet Dnly one ceuse | Dn each lina. | _ | - and or aying, see | in all darance or reap | natory arreat, | Interval Between |
| 章 5 2 | | iMMEDIATE CAUSE (Final disease or condition | A17 | HEIM | = 0/c | NIS | EAS | | Onset and Death |
| letely emat | | resulting in death) | | | | 100 | 1 H 3 | - | |
| executed within and completely to bunal, crematic matic event, it | | | DUE 10 (0 | RAS A CONSEQUENCE | ONLIA | | | | |
| atic | 8 | Sequantielly list conditions, | - | W. P. | | | | | |
| be es | CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | (= 0 | R AS A CONSEQUENCE | | VLAR | NICE | A.CE | i |
| physician ne prior t | 길 | CAUSE (Disease or injury | c. | R AS A CONSEQUENCE | | VLM | | MOL | |
| nding phy Hygiene p | 1 = 1 | that initiated events resulting in death) LAST | F CC F | H AS A CONSEDUENCE | OF): | 1000 | THROI | MRAS | 151 |
| attending attending ntal Hygie Y, or oth | 15 | | "F27E | 11/11/11 | LI | TYERT | THROI | DAL. | |
| y the attended Mental | I 1 | PART ii. Other algnificant condition | ne contributing to de | eath but not requiting | in the underly | ng causa given in | | | 24b. WERE AUTOPSY FINDINGS |
| - P | EDICAL | | | | | g | PERFOR | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| quires that signed to Health a dows any | | - | | | | | 1 YES 2 | XNO | OF DEATH? |
| been sign bt. of Heal | Σ | DID TORAGES III | 601 | | | | | ./ | 1 TES 2 NO |
| | AN: | DID TOBACCO USE | CONTRIBUTE | TO CAUSE (| OF DEATH | YES NO | P □ | | |
| N: The law ficate has State Dep item 23 | SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | T | PLACE OF DEATH (Ch | eck only one) | | |
| SICIAN: The certificate the State I, or iten | lS. | 1 TES 2 NO | | R/Outpatient 3 DOA | OTHER: | ome 5 Reeldence | 6 Other (Specify) | | |
| this ce with th | PHY | 27. MANNER OF DEATH | 28e. DATE DF IN (Month, Day, | | | NJURY AT YORK? | 26d. DESCRIBE HOW I | NJURY OCCURE | 0 |
| nG PHYS fer this eath with marked | ВУ | 1 Natural 5 Pending 2 Accident Investigation | | | | YES 2 NO | | | |
| After death | | 3 Suicide 8 Could not be | 28e. PLACE OF I building, etc | NJURY At home, fern | , street, lectory, of | fice | 261. LOCATION (Street | end Number or Ru | ral Route Number, |
| E S S | TED | 4 Homicide determined | bonding, st | c, (Opecny) | | | City or Town, State) | | |
| | F | 29e. CERTIFIER CERTIFYING PHYS | BICIAN: To the best of m | y knowledge death east | mad at the time of | | | | |
| 7 3 E = | 產 | anal | | | | | | | se(e) end menner ee stated. |
| A de so | 8 | | | | tion, in my opinion | death occured at the | time, date end piace, en | id due to the ced | se(e) end menner ee stated, |
| 音楽を | BE | 296. SIGNATURE AND TITLE OF CERTIFIE | The land | Alter | dis | 29c. LICENSE NUI | MBER | 29d. DATE SIG | NED (Month, Day, Year) |
| TO THE HO TO THE Full be filled with | | Hours. | M-XX | D. 10% | mark | D14170 | | 9/5 | /94 |
| | 유 | 30. HAME AND ADDRESS OF PERSON W | HD COMPLETED CAUSE | OF DEATH (ITEM 27) (7) | pe, (Print) | C.L. | | | |
| | | Harjit Singh ^M · | 410A Ritch | nie Highway | Baltim | ore, Marv | land 21225 | | |
| | | 31. DATE FILED (MODIFY DOX 200) | /32. REGISTRAR'S | S SIGNATURE | | | | | |
| | | SEP U / 1994 | Juli Dands | m-Rendell | | | | | |
| | | · · · · · · · · · · · · · · · · · · · | <i>V</i> | • | | | | | |

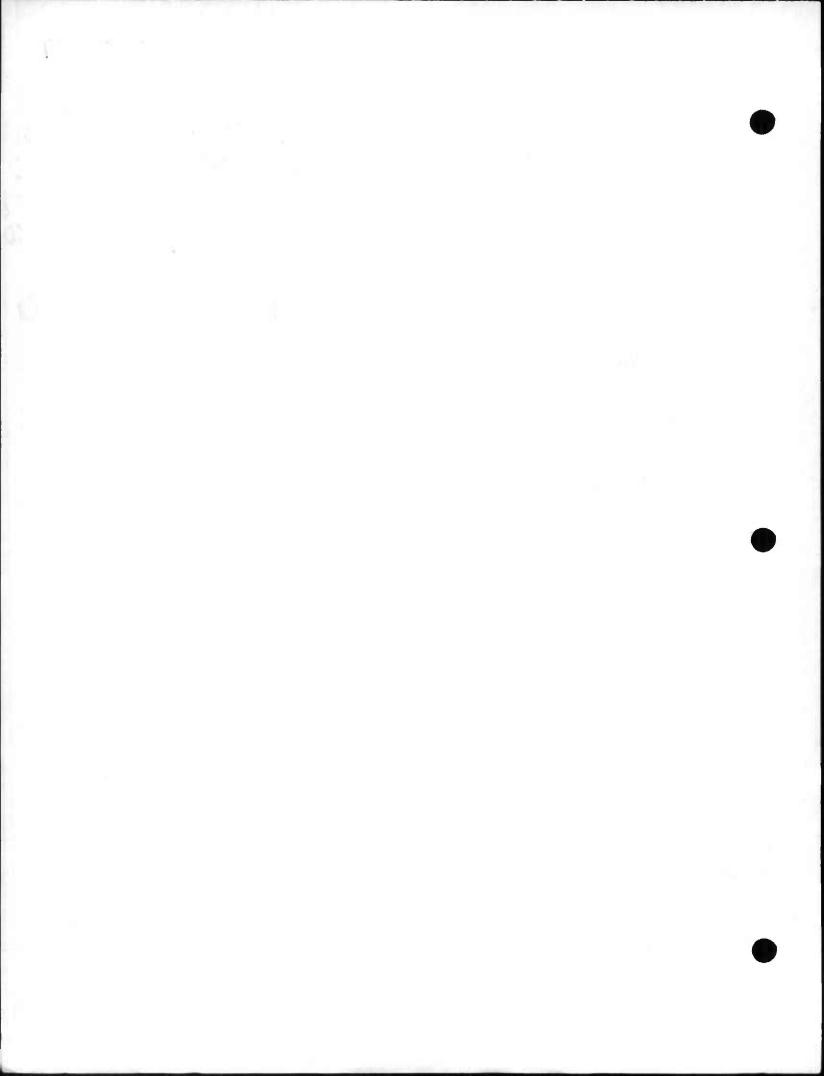
U.I.

BALTIMORE, MARYLAND 21215-0020

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| TOL MINE DECONDS, P.O. BOA 80780, | he law requires that the death certificate he executed with |
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| | Pages | | |
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| | permit. | | |
| fours after death. Page 6 may be retained by the hospital or attending physician. | ATHE THE CATHOLIE has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 | | |
| he hosp | detacher | | 9000 |
| retained by ti | 5 should be | | martin at lam 23 shows any Intern or other transfer event the medical available he mailtied at once |
| пау ре | c page | | of he |
| Page 6 | al director | | inar min |
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| | 1 - FOR STATE REGISTRAR | STATE OF MAR | | DEPARTME RTIFICA | | | MENTAI | L HYGIEN | E | | | |
|------------|--|--|---------------------|------------------------------------|-----------------|--------------------------------|------------------|------------------------------------|---|----------|--|-------|
| | | rcus | L. 1 | BASI | CO | | 2. DATE MONTH | OF DEATH | 19 | 7 | 3. TIME OF DEATH | M |
| | 4. SOCIAL SECURITY NUMBER 550-54-2259 | 5. SEX. 6. / | AGE (In yrs. lest b | birthday) IF UI MONT | THE DAYS | IF UNDER 24 HRS. HOURS MIN. | (Month | OF BIRTH h, Day, Year) | | Country | | sign |
| | 9a. FACILITY NAME (If not institution, give s | street and number) | | 9b. | CITY, TOWN O | R LOCATION OF DE | | KO I | 9c. COUNTY | | Isiana | |
| OH | Harbor Hospital Center Baltimore ===== | | | | | | | | | === | | == |
| 5 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | | | | | | | | | 404 INDIDE CITY | |
| DIRECTOR | | ne Arundel | | Balti | | ON | | | 10d. INSIDE CITY LIMITS? 1 YES 2 XXVNO | | | |
| | 10e. STREET AND NUMBER | | | | | ZIP CODE | | 1 | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| BY FUNERAL | 4810 Marshall Ro | ad | | | | 21225 | | | U.S.A. | | | |
| | 11. MARITAL STATUS | 12. WAS DECEDENT EV | | | | ENDENT OF NISPAN | | | or No- 14, | | - American Indian White, etc. | ١, |
| 2 | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? NOT | | | | 2 NO Specify | | Tirbuit, Gauss | | Specif | | |
| 9 | 15. OECEDENT'S EOU | Viet Na | 16a. OECE | EDENT'S USUA | AL OCCUPATIO | in . | 16b. | KINO OF BUS | INESS/INDUS | TRY | MIII CE | |
| | (Specify only highest grade | College (1-4 or 5+) | (Give | e kind of work do NOT use retin | done during mos | during most of working | | | | | | |
| COMPL | 12th Grade | | Sec | curity | | | A | llied | Chemic | a1 | | |
| 3 | 17. FATNER'S NAME (First, Middle, Lest) | | | | | 16. MOTNER'S NA | ME (First, A | | | | | |
| n n | Joe Basco | | | | | Louid | | - | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) Norma R. Basco | | | | | Number or Rural | | | | | 21225 | |
| | 20a. METHOD OF DISPOSITION | | 20b. PLACE AND | | | Road, B | Salt11 | | arylan | | 21225 | |
| | 1 X Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | noval from Stata | cemetery, crema | atory or other pla | lace) | | 9/ | | | | | |
| į | 21. SIGNATURE OF FUNERAL SERVICE LIC | CENSEE | CEUAL | | Cemete: | D ADDRESS OF FA | CILITY | | timore | | | |
| | Decome & | Frances | ushi | | 4001 | Ritchie | | once F | | | | |
| | 23. PART I. Enter the diseases, or | complications that ca | sused the deet | th. Do not e | nter the mo | de of dying, suc | h aa cerd | diac or reapi | ratory arrest | I'IC | Approximat | ie |
| | ehock, or heart failure. List only one ceuse on esch line. IMMEDIATE CAUSE (Finel disease or condition reaulting in deeth) a. Metastata Immatural Caramora of kidney DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| HILICATION | Sequentially list conditione, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury c. | | | | | | | | | | | |
| CENIE | that initiated evente reaulting in deeth) LAST | d | AS A CONSEOU | ENCE OF): | | | | | | | | |
| A | PART II. Other significant condition | ns contributing to dec | ath but not ree | uiting in the | e underlylng | ceuse given in | Part I. | 24a. WAS AN PERFOR 1 YES 2 | MED? | | WERE AUTOPSY FINE AMAILABLE PRIOR TO COMPLETION OF CAL | 0 |
| MEDIC | | | | | | | | · [| | ı | OF DEATH? | |
| _ , | DID TOBACCO USE (| CONTRIBUTE T | O CAUSE | OF DE | ATH Y | ES NO | | | | | taur | |
| HYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OT | | ACE OF DEATH (Ch | eck only on | ю) | | | | |
| 2 | 1 TYES 2 NO | 1 - Inpatient 2 - ER | | DOA 47 | | 5 - Realdence | 8 🗆 Other | r (Specify) | | | | |
| E | 27. MANNER OF DEATN 1 Natural 5 Pending | 28s. DATE OF INJI (Month, Day, Y | | 28b. TIME OF INJURY | 28c. INJU WO | RK? | 26d. OES | CRIBE NOW II | JURY OCCUR | ED | | |
| ā | 2 Accident Investigation | 28s. PLACE OF IN | IIIRY — At hom | - form street | | ES 2 NO | 204 100 | ATION (Ormal o | * | - 10 | | |
| | 3 Suicide 6 Could not be detarmined | building, atc. | (Specify) | | | | City | ATION (Street a or Town, State) | | Rurei Ho | oute Number, | |
| COMPLE | | BICIAN: To the best of my ER: On the basis of exami | | | | | | | | nuse(a) | and menner as stat | ited. |
| | 29b. SIGNATURE AND TITLE OF CERTIFIED | A / | | | | 29c. LICENSE NUI | 0 0 | | 29d. DATE SI | GNED | (Mogth, Day, Year) | |
| 2 | (An Work | levan m | 0 | | | 1)227 | 82 | | 181 | 131 | 1/94 | |
| | 30. NAME AND ADDRESS OF PERSON WN | O COMPLETED CAUSE O | F DEATH (ITEM 2 | 5/1/ (Type, Print) | King. 7 | al Ce | ter | 1 | | | | |
| | 31. DATE FILED (Month, Day, Year) SEP 0 7 1994 | 32. REGISTRAR'S | SIGNATURE | 700 11 | 6 | | ., 0 | | - | | | |
| | C L D A 7 100 A | | | | | | | | | | | |



| | | isit permit. Pages 1, 2, 3 should |
|-------------------------------------|---|---|
| AND 21215-0020 | ITENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should |
| BALTIMORE, MARYLAND 21215-0020 | eath. Page 6 may be retained by I | funeral director, page 5 should be |
| X 68760, | e executed within 24 nours after d | an and completely filled in by the |
| N OF VITAL RECORDS, P.O. BOX 68760, | equires that the death certificate t | en signed by the attending physici |
| ISION OF VITAL H | TTENDING PHYSICIAN: The law n | TOR: After this certificate has be |
| AIO. | TO THE HOSPITAL OR A | TO THE FUNERAL DIREC |

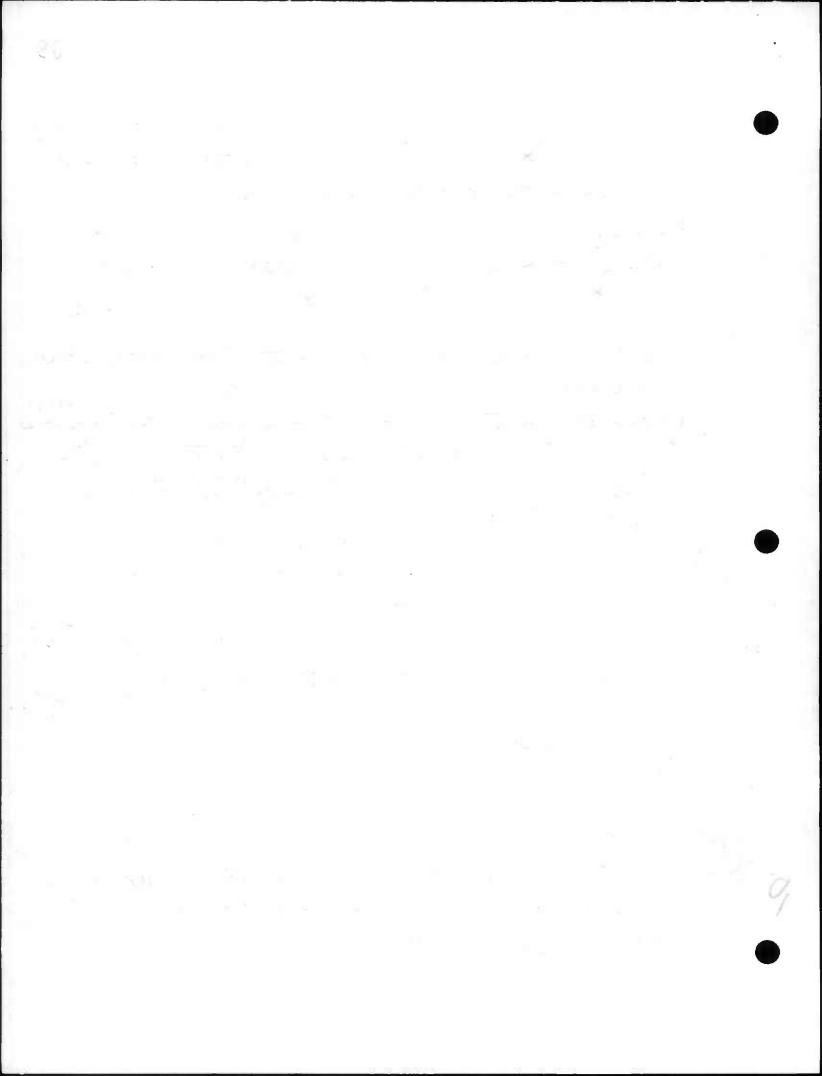
| | | 1 - STATE REGISTRAR | STATE OF MARYL | | TMENT OF H | | MENTAL HYGIENE REG. NO. | | | | |
|---|-----------------|--|---|---|--------------------------------------|--------------------------------------|--|---------------------|--|--|--|
| | • | 1. DECEDENT'S NAME (First, Middle, Lest) | GER HA | +RDT | BAL | DWIN | 2. DATE OF DEATH DAY | Y Q YEAR | 3. TIME OF DEATH | | |
| | UNERAL DIRECTOR | 4. SOCIAL SECURITY NUMBER | 5. SEX 8. AGE (| In yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRT | HPLACE (State or Foreign | | |
| | | 213-03-5773 9a. FACILITY NAME (If not institution, give st | | 6 YRS. | | OR LOCATION OF DE | 01-07-1918 | 8 Ma | ryland | | |
| | | Carroll County General Hospital Westminster Carroll County | | | | | | | | | |
| | | 10e. STATE 10b. COUNTY | | | Y, TOWN OR LOCA | TION | | | 10d. INSIDE CITY LIMITS? | | |
| | | Maryland Ca | rroll County | | Sykesy | ille . zip code | | 10g. CITIZEN OF | 1 TY YES 2 NO | | |
| | | 308 Anna Lane | | | | 21784 | | U,S. | | | |
| | BY F | 1 MARITAL STATUS 1 Never Married 2 X Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR DA | 2 NO | If yes, sp | ecity Cuben, Mexicar 2 NO Specify | | | E — American Indian, k, White, etc. //y: White | | |
| | ETED | 15. DECEDENT'S EDUC (Specify only highest grade | completed) | | USUAL OCCUPATION Work done during mo | | 16b. KIND OF BUS | INESS/INDUSTRY | | | |
| _ | COMPLE | Elementary/Secondary (0-12) | College (1-4 or 5+) | | iceman | | Baltimo | ore City | Police | | |
| nt onc | - 1 | 17. FATHER'S NAME (First, Middle, Lest) Wilbur F. | Poldwin | | | | AE (First, Middle, Maiden S | Surneme) | | | |
| Hed a | D BE | 19a. INFORMANT'S NAME (Type/Print) | Daldwin | 19b. MAILING | ADDRESS (Street | | istina Mar | | n | | |
| be no | 5 | Mrs. Marie J. Ba | | | | | ville, MD | | | | |
| must | | 1 Buriel 2 Cremation 3 Remo | oval from State Cert | PLACE AND DATE OF PRINCIPLE OF | ther plece) | al Park 9 | 1 | CATION — City or To | | | |
| or removal. medical examiner must be notified at once. | | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE // | 1. | 22. NAME A | O ADDRESS OF FAC | | | | | |
| removal. | _ | 23. PART I. Enter the diseases, or c | - Herel | 7 | Svl | cesville. | MD 21784 | (410) - 7 | 95-1400 | | |
| | | ahock, or heart failure. I IMMEDIATE CAUSE (Final | List only one cause on a | ach lina. | or anter the me | da or dying, aucr | sa cardiac or reapir | atory arrest, | Approximate Interval Between Onset and Death | | |
| vent, the | | disease or condition resulting in death) | Dilling | CONSEQUENCE OF | Cone | Stue | heart f | aller | Real | | |
| burial, ci | z | | Leval | Farly | he, | Corono | a out | | | | |
| prior to burial, crema traumatic event, | CATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | CONSEQUENCE OF | Butu (| ulas + | e chua | ndep | | | |
| Hygiene p | RTIFIC | CAUSE (Disease or Injury that initiated events | DUE TO (OR AS A | CONSEQUENCE OF | 701.1 | 2 | | - | | | |
| - 6 | CER | resulting in death) LAST | , Diabelle | 5 Miles | yll bu | 5/4 | | | | | |
| g = | CAL | PART II. Other significant conditions | s contributing to death b | ut not resulting | in the underlyin | cause given in a | PERFORM | MED? | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE | | |
| shows amy | MEDIC | | | | w prosec | | 1 TYES 2 | (DNO | OF DEATH? | | |
| | AN: | 25. WAS CASE REFERRED TO MEDICAL | | | | | | | | | |
| or Item 23 | SIC | EXAMINER? | HOSPITAL: | eatlant 3 🗆 DOA | OTHER: | ACE OF DEATH (Che | 177 - 7 | | | | |
| With the | ВУ РНУ | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 26e. DATE OF INJURY (Month, Day, Year) | 28b. TIM | | BK? | 28d. DESCRIBE HOW IN | JURY OCCURED | | | |
| after d | ETED 8 | 3 Suicide 8 Could not ba 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Spec | — At home, ferm, s | street, factory, offic | • | 281. LOCATION (Street or City or Town, State) | nd Number or Rural | Route Number, | | |
| within 72 hours | COMPLE | | CIAN: To the best of my know R: On the basis of exemination | | | | | | e) end manner ee stated, | | |
| be filed within IMPORTANT: | TO BE | 29b. SIGNATURE AND TITLE OF DEBTY ER | | | | D 389 | BER) | 29d. DATE SIGNED | (Month, Day Year) | | |
| | - | 30. NAME AND ADDRESS OF PERSON WHO | 15 | 42 W | AS H | Rd o | ust ums | laz | 1 | | |
| | | SFD 7 1994 | 1. As me an Ray | | | | | | | | |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last, 2. DATE OF DEATH 3. TIME OF DEATH YEAR 1115 AUSTON SEPTEMBER 4 1994 SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 8. BIRTHPLACE (Stete or Ford -34-8102 1 M 2 F use as the burial-transit permit. Pages 1, 2, 3 should DIRECTOR MARITAN HOSPIT ALTIMORS 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY ARYLAND 70Rs 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21239 the hospital or attending physician 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuben, Mexicon, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Norried BY 1 YES 2 NO Specify: 3 Widowed 4 Divorced COMPLETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only his to to Elementery/Secondery (0-12) College (1-4 or 5 +) 12-YRS funeral director, page 5 should be detached 6YRS. 17. FATHER'S NAME (First Middle Last) Unknown retained by Unknow BE notified t9e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31239 10 PARGARI 1374 And hours after death. Page 6 may be Pe 20e. METHOD OF OISPOSITION

1 Suriel 2 Cremetion 3 Rem PATE 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must 4 Donetion 5 Other (Specify) YZOA. VALLEY examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
EVAN CHAPLOF CHIMLS filled in by the cremation, or removal, other traumatic event, the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, Approximate intervel Between ehock, or heert feilure. List only one ceuse on eech iine. IMMEDIATE CAUSE (Finel **Onset and Death** disesse or condition executed with. HIGH DEBREE ATRIOVENTRICULAR BLOCK resulting in desth) DUE TO (OR AS A CONSEQUENCE OF): Mental Hygiene prior to bunal, METASTASIS MYOCARDIAZ MEDICAL CERTIFICATION and Sequentielly liet conditione, DUE TO (OR AS A CONSEQUENCE OF): signed by the attending physician Health and Mental Hygiene prior to If eny, leeding to immediate ceuse. Enter UNDERLYING HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be WITH WETASTASIS COLON CA CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events DIVISION OF VITAL RECORDS, P.O. resulting in deeth) LAST PART ii. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 23 shows any CONONAMY MUTTERLY 1 YES 2 NO OF DEATH? 1 - YES 2 - NO PHYSICIAN: Dept. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 6 the 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED this c marked, 1 Natural Pending Investigation 1 YES 2 NO ВУ After 2 Accident 28e. PLACE OF INJURY — At home, ferm, atreet, tectory, office building, atc. (Specify) 92 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 6 Could not be after m 28 | 4 Homicide 1 DERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner COMB 2 MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opini 29b. SIGNATURE AND TIME OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year, 뿓 046440 1994 2 2 2 2 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GODD SAMBELTAN HOSPIL TANGLAD, M.D.

32. REGISTRAR'S SIGNATURE i Danien-Rudall

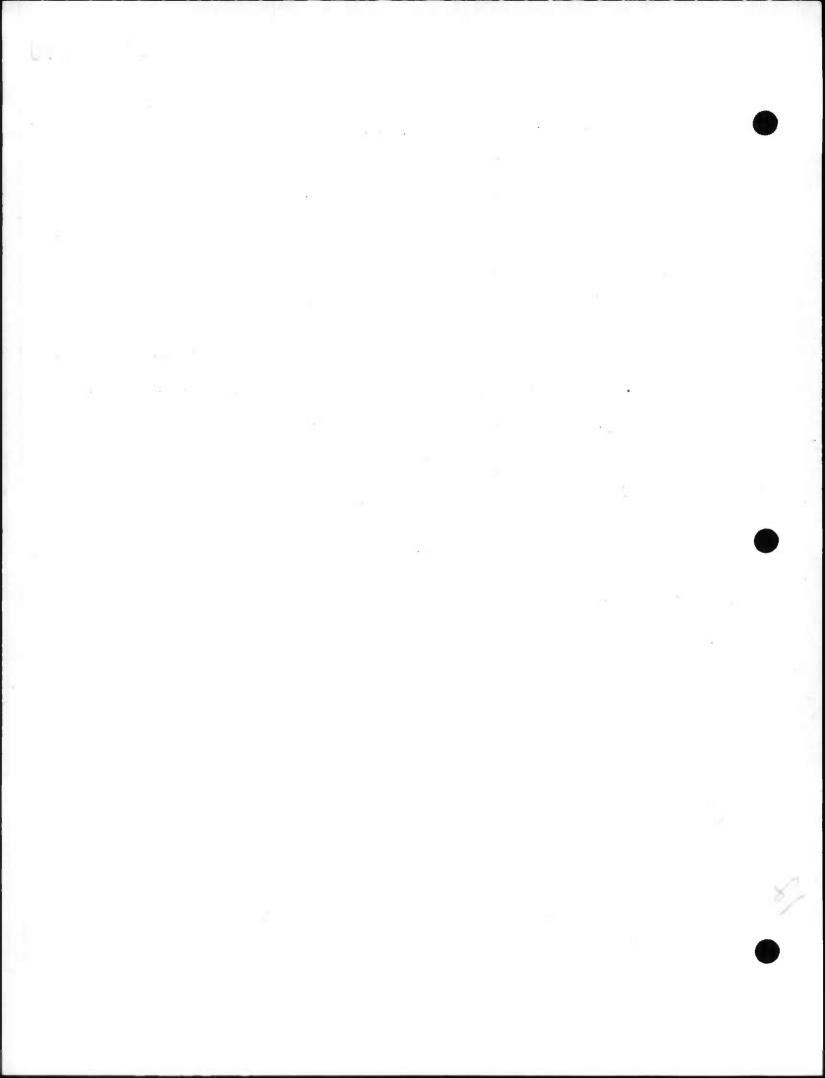


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| retained by the hospital or attending physician. | 5 should be detached for use as the burial-transit permit. Pages | |
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| | | 1 - STATE OF STATE OF REGISTRAR | MARYLAND / DEPARTMENT OF HEA | ALTH AND MENTAL DEATH | HYGIENE REG. NO. | | | |
|--|-----------------------|--|--|--|--|---|--|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) ELEANORE | T. COLLING | 2. DATE (| OF OEATH DAY Y | 3. TIME OF DEATH | | |
| ₽ | | 4. SOCIAL SECURITY NUMBER 5. SEX 1 ☐ M 2 A | 1101-110 | F UNDER 24 HRS. 7. DATE O | OF BIRTH 8. | BIRTHPLACE (State or Foreign Country) WCST. VA | | |
| 1, 2, 3 should | ECTOR | 9a. FACILITY NAME (If not institution, give street and number) 135 GOUCHER WAY RESIDENCE OF DECEDENT | | LOCATION OF DEATH | ec. COUNTY | OF DEATH REGRO | | |
| UZU physician. burial-transit permit. Pages 1 | 띪 | 100. STATE 100. COUNTY HARFOR | | rille | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | |
| an. ransit perr | FUNERAL | 135 GOLCHER WAY | 101. 21 | 21028 | US | OF WHAT COUNTRY? | | |
| | BY | 1 Never Married 2 Married FORCES? | DENT EVER IN U.S. ARMED 1 VES 2 NO E WAR OR DATES 13. WAS OECEN If yee, specifications of the control of the | DENT OF HISPANIC ORIGIN: by Cuben, Mexican, Puerto R NO Specify: | ? (Specify Yas or No— 14. Ican, etc.) | RACE — American Indian, Black, White, atc. Specify: | | |
| ZZZZJS-U vital or attending d for use as the | COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or | 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) LIBRARIAN | of working | KIND OF BUSINESS/INDUS | SCHOOLS | | |
| by the hospital or be detached for u | E COMF | 17. FATHER'S NAME (First, Middle, Last) DALE W. TRYON | 11 | 6. MOTHER'S NAME (First, M | liddle, Maiden Surname) | igher | | |
| MAK retained 5 should notified | TO B | 190. INFORMANT'S NAME (Type/Print) GEOFGE COLLIN | 19b. MAILING ADDRESS (Street end | | er, City or Town, State, Zip Co | | | |
| Page 6 may be director, page | | 20a, METHOD OF DISPOSITION 1 | 20b. PLACE AND DATE OF DISPOSITION (Name cametery, crematory or other place) | | 20c. LOCATION City | | | |
| death. Pe funeral | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND | ADDRESS OF FACILITY CHAPEL VPORT DR | Bel Air Forest | HILL MA 21050 | | |
| within cours at pletely filled in by cremation, or remove them, the medical control of the medical court is the medical court. | | 23. PART I. Enter the diseases, or complications shock, or heart feiture. Liet only one iMMEDIATE CAUSE (Final disease or condition resulting in death) | that caused the deeth. Do not enter the mode | of dying, such ee cerd | ac or respiratory errest | Approximate Interval Between Onset and Death | | |
| th certificate be executed by the certificate be executed by the certificate by the certi | MEDICAL CERTIFICATION | Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE DF): c. DUE TO (DR AS A CONSEQUENCE OF): | | | | | | |
| requires that the sen signed by the of Health and M shows any injury | | PART ii. Other significent conditione contributing | to death but not resulting in the underlying c | euse given in Part i. | 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| SICIAN: The law certificate has be the State Dept. | SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Ingellant | | E OF DEATH (Check only one | | | | |
| The this | у РНУ | 27. MANNER OF DEATH 26s. DATE | OF INJURY 28b. TIME OF 2ec. INJURY NORK | Y AT 28d. DES | (Specify) CRIBE HOW INJURY OCCUR | ED | | |
| DR ATTENDING | 160 | 3 Suicide 26a. PLAC | E OF INJURY — At home, farm, streat, factory, office ng, atc. (Specify) | 281. LOCA City o | TION (Street and Number or in Town, State) | Rural Route Number, | | |
| 4 20 | COMPLI | | t of my knowledge, death occurred at the time, data an of examination end/or investigation, in my opinion, deat | | | suse(s) and manner as stated. | | |
| TO THE HOSPIT TO THE FLACER De fined within 7 | TO BE (| 296. SIGNATURE AND TITLE OF CERTIFIER | | D44544 | 1 | GNED (Month, Day, Year) EMBER 7, 1994 | | |
| | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED O | 1800 Jeffers | ON ST. | | | | |
| | | CED B / 100M 24 | TRAR'S SIGNATURE | | | | | |



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| Fours after death. Page 6 may be retained by the hospital or attending physician. In by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should or removal. Inedical examiner must be notified at once. | TO BE COMPLETED BY FUNERAL DIRECTOR | 237 03 9. 9a. FACILITY NAME (If INC. Frankli: RESIDENCE OF D. 10a. STATE Maryland 10b. STREET AND NUMB 9 Mi 11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 C. (Specify) Elementary/Secondar 17. FATHER'S NAME (First Char: 19a. INFORMANT'S NAME Frances A 20a. METHOD OF DISPO 1 ABURIAL 2 Crem 2 Community Secondar 2 Community Secondar |
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| ENDING PHYSICIAN; The law requires that the death certificate be executed within Flours after death. Page 6 may be retained by the hos. IR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detact like death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | ED BY PHYSICIAN: MEDICAL CERTIFICATION | 23. PART I. Enter the ehock, o IMMEDIATE CAUSE (disease or condition resulting in death) Sequentially list con if any, leeding to improve the cause. Enter UNDER CAUSE (Disease or in the initiated eventa resulting in deeth) L PART II. Other aignification of the content of the content of the cause. Enter UNDER CAUSE (Disease or interest of the cause) PART II. Other aignification of the cause |

| 1. DECEDENT'S NAME (First, Middle, Lest) MOTTS LUCCIO CROM 4. SOCIAL SECURITY NUMBER S. SEX S. AGE (In yrs. lest birthday) F. U. | ATE OF DEATH | ENTAL HYGIENE REG. NO. | | | | | |
|--|--|--|--|--|--|--|--|
| 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (in yrs. last birthday) IF U | Croom | 2. DATE OF DEATH | 3. TIME OF DEATH | | | | |
| 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (in yrs. last birthday) IF U | | MONTH DAY | 94 7:36 P M | | | | |
| | INDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | | | | | |
| 237 03 9136 1 M 2 F 72 YRS. | THE DAYS HOURS MIN. | April 22, 19 | 22 Country N.C. | | | | |
| Franklin Sq. Hospital | Pa. FACILITY NAME (If not institution, give street and number) Pranklin Sq. Hospital Possville Baltimore | | | | | | |
| RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY 10c. CITY TO | | | | | | | |
| Maryland Baltimore | WHO ORLOCATION River | | 10d, INSIDE CITY LIMITS? 1 YES 2 NO | | | | |
| 10s. STREET AND NUMBER | 10f. ZIP CODE | 10g. | CITIZEN OF WHAT COUNTRY? | | | | |
| 9 Mitchell Rd. | 21226 | | USA | | | | |
| 11. MARITAL STATUS 1 Never Married 2 Married 5 Never Married 2 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR BATES | 13. WAS DECENDENT OF HISPANIC If yes, specify Cuban, Mexicen, 1 YES 2 Mao Specify: | | 14. RACE — American Indian, Black, White, atc. Specify: White | | | | |
| 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUA | | 16b. KIND OF BUSINESS | I S/INDUSTRY | | | | |
| (Specify only highest grade completed) (Give kind of work of life. Do Not use retired to the control of life. Do Not use retired to the control of life. Do Not use retired to the control of life. Do Not use retired to the control of life. | lone during most of working red.) Worker | Const | cruetion | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles Thomas Croom | 18. MOTHER'S NAM | E (First, Middle, Maiden Surner ah Anderson | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADD | RESS (Street and Number or Rural Ro | usta Mumbar City or Town State | 7 To Code) | | | | |
| Frances A. Lambert, Sister 9 Mitches | ell Rd. Baltim | ore, MD 2122 | 20 | | | | |
| 20a. METHOD OF DISPOSITION 1 (X Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) | | | N — City or Town, State on Forest Balto Co | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACI | 1. ' | | | | | |
| Money & Saway Syework | 1407 Eastern | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not a | | | | | | | |
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. Pneumonia | | | Interval Between Onset and Death | | | | |
| f any, leeding to immediate | | | | | | | |
| cause. Enter UNDERLYING | | | | | | | |
| if any, leeding to immediate | | | | | | | |
| if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST | e underivina ceuse alven in P | ert I. 24a. WAS AN ALITO | PSY 24h WERF AUTOPSY FINDINGS | | | | |
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | REGISTRAR | | | | CALE | F DEATH | REG. NO. | | |
|------------------------------|---|---|--|--|--|--|---|--|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
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| | HEZEKIAH | | COULTAIN | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 216-28-3824 | | 6. AGE (In yrs. lest | | MONTHS DAY | | 7. DATE OF BIRTH (Month, Day, Year) | | BIRTHPLACE (State or Foreign Country) Country 1 | 1 | 1 🔀 M 2 🗆 F | 01 | YRS. | | I I I I I I I I I I I I I I I I I I I | AUG. 8, 19 | 33 | S. CAROLINA |
| | 9e. FACILITY NAME (If not institution, give s | street and number) | | | 9b. CITY, TOV | VN OR LOCATION OF D | | | TY OF DEATH |
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| DIRECTOR | RESIDENCE OF DECEDENT | | | | BAL | TIMORE | | IN | I/A |
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| ž | 11. MARITAL STATUS | T | | | _ | | | | |
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| | Met V. | m-cu | 114 | | 110 | l E. NORTI | AVE./BALT | 'IMORE | E, MD 21202 |
| | 23. PART I. Enter the diseases, or others fellure | Complications that | caused the day | ith. Do n | ot anter tha | moda of dying, aud | h aa cardiac or respi | ratory arre | |
| | shock, or haart fallura. List only one cause on each line. Interval Between Onset and Daeth | | | | | | | | |
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| | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | AND / DEPART | MENT OF H | EALTH AND | MENTAL HYGI | | | | | | |
|------------------|---|---|---|---|-------------------------------------|---|----------------------------|----------------------|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | 1 | | TIME OF DEATH | | | |
| | Pauline CA | PPALONG | -A | | | монти | - 10 - | YEAR | 1555 VM | | | |
| | 4. SOCIAL SECURITY NUMBER | | | ONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Yea | | BIRTHPLA Country) | ICE (State or Foreign | | | |
| J | | 1 🗆 M 2 💢 F 10 | Z YRS. | | | 10/19/1 | | Ital | У | | | |
| œ | 9e. FACILITY NAME (If not institution, give sti | | 1 | | R LOCATION OF DI | EATH | 9c. COUNT | Y OF DEAT | н | | | |
| 5 | St. Agnes Hospital Baltimore City | | | | | | | | | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LOCAT | ION | | | 100 | I, INSIDE CITY LIMITS? | | | |
| | | ltimore | Ar | butus | _ | | | 1 [| YES 2 X NO | | | |
| RAI | 100. STREET AND NUMBER | ing Dood | | 101 | ZIP CODE | | U.S. | | COUNTRY? | | | |
| FUNERAL | 1217 Sulphur Spr | 12. WAS DECEDENT EVER IN | IIS ADMED | 21227 S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Y | | | | | | | | |
| | 1 Never Married 2 Married | FORCES? 1 YES | 2 NO | It yes, sp | city Cuban, Mexica 2 XNO Specifi | in, Puerto Rican, etc. | Year or No.— | Black, Wi | American Indian, hite, etc. | | | |
| ВУ | 3 XWidowed 4 Divorced | | | 1 | L LA.110 Opposi | white | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade of | :ATION completed) | 16a. DECEDENT'S US (Give kind of wor | rk done during mo | IN st of working | 16b. KIND OF | BUSINESS/INDU | STRY | | | | |
| | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use i | , | | | _ | | | | | |
| NO. | 17. FATHER'S NAME (First, Middle, Last) | | Homema | ıker | 18 MOTHER'S NA | Sel | | | | | | |
| BE C | Philip Ferrerre | | | | Anna Ca | | uen surname) | | | | | |
| TO B | 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAILING A | DDRESS (Street a | | Route Number, City or | Town, State, Zip C | Code) | | | | |
| F | Thomas Cappalonga | | 1217 S | ulphur | Spring I | Road, Arb | utus, M | ID 21: | 227 | | | |
| | 20e. METHOD OF DISPOSITION 1 Description 3 Permotestical Research | | PLACE AND DATE OF | DISPOSITION (Na | | | LOCATION — CI | | | | | |
| | 4 Donetion 5 Other (Specify) 21. BIGNATURE OF FUNERAL SERVICE LICE | IA | oudon Par | k Cemet | ery | 19/6 Ba | ltimore | . Mar | yland | | | |
| - 1 | 000 | 5 | 0 | 1220 0 | ulabum (| Ambro | se Fune | ral F | Home, Inc. | | | |
| | pala | te | -20. | 1 | | | | | MD 21227 | | | |
| 0 | 23. PART I. Enter the diseases, or cashock, or heart failure. L | omplications that caused List only ona cause on as | the death. Do not ch line. | l enter the mo | de of dyling, suc | h es cerdiac or re | spiratory arres | st, | Approximate interval Between | | | |
| | iMMEDIATE CAUSE (Final disease or condition | at - | >1. | | | | | | Onset and Death | | | |
| | resulting in death) | DUE TO (OR AS A | CONSEQUENCE OF: | (0 | IPPER) | | | | 18 HRS | | | |
| z | | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| 25 | CAUSE (Disease or injury | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | | | |
| Ē | that initiated events resulting in deeth) LAST | OUL TO (OR AS A | CONSEGUENCE OF): | | | | | | | | | |
| | DART II Oak a also Missas as a Missas | | | | | | | | | | | |
| CAL | PART II. Other significant conditions | contributing to death bu | it not rasulting in | tha undarlying | ceuse givan in | | AN AUTOPSY FORMED? | AWA | RE AUTOPSY FINDINGS JILABLE PRIOR TO | | | |
| ED | | | | | | 1 □ YES | 2 NO | OF | MPLETION OF CAUSE DEATH? | | | |
| Σ | DID TOBACCO USE | CONTRIBUTE TO | CAUSE OF | DEATH ' | YES [] NO | | | 1 [| YES 2 NO | | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL | | | | ACE OF DEATH (Ch | - 2 | | 1 | | | | |
| Sic | EXAMINER? | HOSPITAL: 1 Kinpatient 2 ☐ ER/Outpe | | THER: | 5 Residence | 6 Other (Specify) | | | | | | |
| F | 27. MANNER OF DEATH | 28s. DATE OF INJURY (Month, Day, Year) | 286, TIME (| OF 28c. INJ | | 28d. DESCRIBE HO | W INJURY OCCU | RED | | | | |
| B | 1 Natural 5 Pending 2 Accident Investigation | | | M 1 🗆 1 | ES 2 NO | | | | | | | |
| | 3 Suicide 8 Could not be determined | 28e. PLACE OF INJURY building, etc. (Special | — At home, term, stre | et, fectory, office | • | 28t. LOCATION (Str. City or Town, St | set and Number or late) | Rurel Route | Number, | | | |
| Li I | an Appring | | | | | | | | | | | |
| COMPLETED | (Check only 1 CERTIFYING PHYSIC | CIAN: To the best of my knowle | | | | | | | | | | |
| | 296. SIGNATURE AND THE OF CERTIFIER | R: On the beels of exemination | end/or investigation, | In my opinion, d | | | | | - 1711 | | | |
| BE | 8 Line | \bigcirc | | | 29c, LICENSE NUI | 836 | 29d. DATE | SIGNED (Mo | nsh, Day, Year) | | | |
| 임 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEA | TH (ITEM 27) (Type, Pr | rint) | レコ | 0 76 | | 12 | | | | |
| | Cierald + | tayward | | | | | | | | | | |
| | SEP 0 1 1994 | 32 REGISTRAR'S SIGNA | | | | | | | | | | |
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| _ | 1 - STATE STATE OF MARYLAND / DEPARTMENT CERTIFICATE | OF DEATH | MENTAL HYGIE! REG. NO | | | | | | | |
|---------------|--|--|---------------------------------------|-----------------|---|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) AKA Jean CMARGARET J. CORDE | LL | 2. DATE OF DEATH | DAY 94 YEA | 3. TIME OF DEATH | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthdey) 1 M 2 F 54 YRS. 98. FACILITY NAME (If not institution, give street and number) 99. CITY, | 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN. TOWN OR LOCATION OF D | 7. DATE OF BIRTH (Month, Day, Year) | Co | RTHPLACE (State or Foreign unity) Pennsylva: F DEATH | | | | | |
| СТОВ | Harbor Hospital Ba | ltimore M | ld. | | | | | | | |
| DIREC | 10a. STATE 10b. COUNTY 10c. CITY, TOWN O | Burnie | | | 10d. INSIDE CITY LIMITS? | | | | | |
| ERAL | 10e. STREET AND NUMBER | 10f. ZIP CODE | | | 1 ☐ YES 2 ☐ NO F WHAT COUNTRY? | | | | | |
| BY FUNE | 1 Never Married 2 Married FORCES? 1 YES 2 NO | 21061 MAS DECENDENT OF HISPA yea, specify Cuban, Maxic. YES 2 NO Specify X X | an, Puarto Rican, etc.) | es or No— 14. R | S.A. ACE — American Indian, lack, White, atc. Decity: White | | | | | |
| | 15. OECEDENT'S EOUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade 16e. DECEDENT'S USUAL OF (Give kind of work done of life. Do NOT use retired.) homemak | CUPATION uring most of working | | USINESS/INOUSTR | | | | | | |
| BE COMPLET | 17. FATHER'S NAME (First, Middle, Last) Leroy Gray | 18. MOTHER'S NA | AME (First, Middle, Melder irginia | | | | | | | |
| 10 | Daniel I. Cordell 7142 Bal | (Street and Number or Rural to . Annap. | Blvd. G | len Bu: | rnie Md. | | | | | |
| | 1 Burlal 2 Crematton 3 Ramoval from Stata 4 Donation 5 Other (Specify) Metro Crem | | 9/1 B | altimo: | | | | | | |
| | Janua M Zramuiouski. 4001 Ritchie Hwy. Baltimore Md. | | | | | | | | | |
| CERTIFICATION | 23. PART I. Enter the diseasea, ar complicatione that caused the deeth. Do not enter the mode of dying, such as cardiec or reapiratory arrest, shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST Approximate interval Between Onset and De Due fo (or as a consequence of): - CR F b. Due to (or as a consequence of): - Osteomyell to cause interval Between Onset and De Due to (or as a consequence of): - Osteomyell to cause interval Between Onset and De | | | | | | | | | |
| MEDICAL | PART ii. Other significent conditions contributing to death but not resulting in the un | | | RMED? | 24b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | |
| HYSICIAN: | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEAT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? MOSPITAL: OTHER | 26. PLACE OF DEATH (C) | | | | | | | | |
| BY PHYS | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 28. PLACE OF INJURY (Month, Day, Year) 28. PLACE OF INJURY (Month, Day, Year) 28. PLACE OF INJURY (Month, Day, Year) | Ing Home 5 Residence 28c. INJURY AT WORK? t YES 2 NO | 28d. DESCRIBE HOW | | | | | | | |
| COMPLETE | 3 Suictide 4 Homicide 8 Could not be datarmined 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the the manner of the best of th | ne, data and place, and du | | nner as stated. | | | | | | |
| TO BE C | 296. SIGNATURE AND TITLE OF CERTIFIER PITAYACLT JUMPANDARIKAL 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HARBOR HOSPITAL OTR. 2001 | S. HANOV | | ▶ 8 | NED (Month, Day, Year) - 31-94 TIHORE M | | | | | |
| | 31. DATE FILED (Month, Day, Year) SEP 0 7 1994 SLin Danies Registrar's SIGNATURE | | | | | | | | | |

31.35 Ag

TO THE HOBERTAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hospital or attending physician.

TO THE HUNGAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be fluid within more many marked, and the burial-transit permit. Pages 1. 2, 3 should be fluid within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT ILLEM A IS marked, or liem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

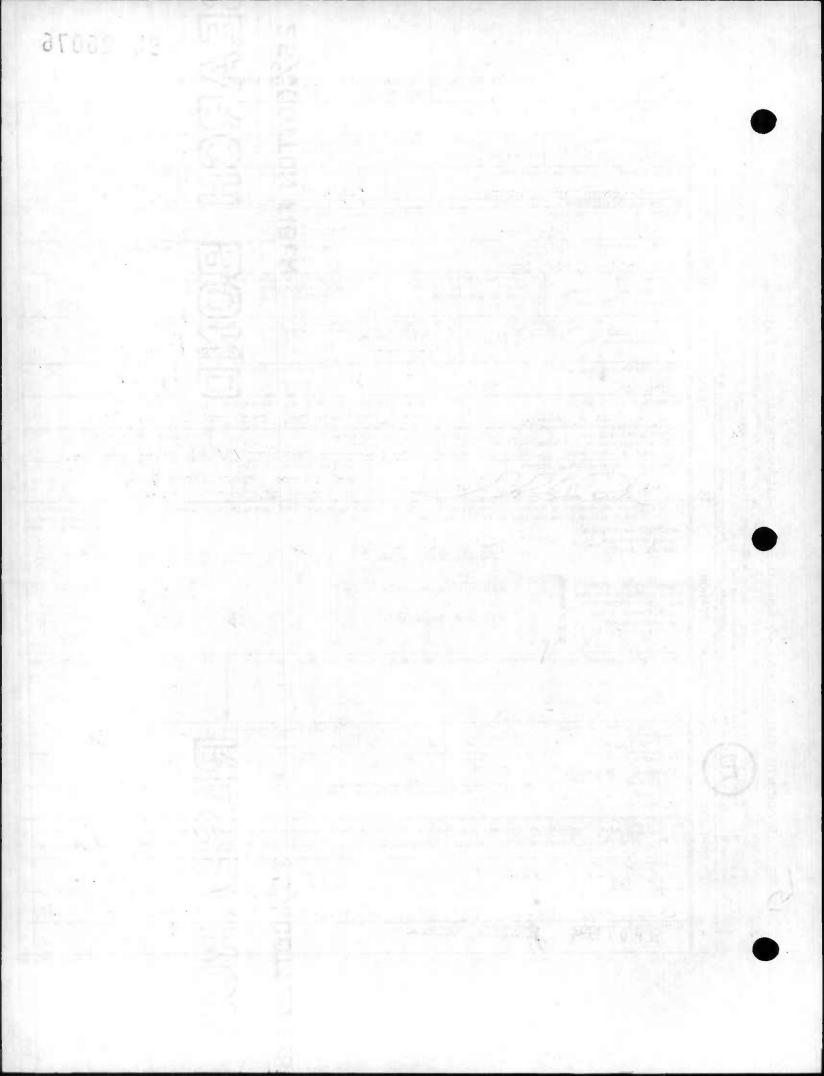
| | | 1120.011341 | | | | | IOAIL | . 01 | DLA | 111 | P | IEG. NO. | | | | |
|---------------|---|--|---------------|------------------------------------|-------------------|----------------|------------------------------------|--------------------|-----------------|----------------------|----------------------------------|-------------|---------------------------|--|--------------------------------|----------------------|
| | i | 1. DECEDENT'S NAME (First, Middle HELEN L. | | ARR | | | | | | | 2. DATE OF MONTH | DEATH D | NY . | YEAR 4 | 3. TIME OF D | |
| | -1 | 4. SOCIAL SECURITY NUMBER | 5. SEX | . SEX 6. AGE (In yrs. lest birthd) | | | IF UNDER 1 YEAR IF UNDER 24 HRS. | | | 7. DATE OF BIRTH | | | • • | | | |
| | | 234 34 3630 1□м2№ 67 | | | | YRS. | MONTHS DAYS HOURS MIN. | | | | (Month, Day, Year) 03/09/1927 | | | 8. BIRTHPLACE (State or Foreign Country) West Virginia | | - |
| 1 | | 9e. FACILITY NAME (If not institution | , give stree | et and number) | | | 9b. CITY, | TOWN | OR LOCATI | ON OF DE | ATH | | 9c. COL | JNTY OF D | | |
| l œ | | Harbor Hospital Center | | | | | Ba1 | t i ma | ore | | | | === | ==== | | |
| ΙĶ | | RESIDENCE OF DECEDENT | | | | | | | | | | | | | | |
| m | | 10e. STATE 10b. 0 | COUNTY | | | 10c. Cf1 | Y, TOWN O | R LOCA | TION | | | | | | 10d. INSIDE C | HTY |
| DIRECTOR | - 18 | 1 | ==== | == | | Ba | altim | ore | | | | | LIMITS? 1 1 YES 2 □ NO | | | |
| FUNERAL | | 4012 - 4th S | tree | t | | | | 10 | 1. ZIP COD | | | | | | WHAT COUNTRY | r |
| 1 2 | | | | | | | | | | | | | | J.S.A | 1. | |
| 15 | | 11. MARITAL STATUS 1 Never Married 2 Married | | 2. WAS DECEDEN FORCES? 1 | T EVER IN U.S. A | | 13. V | VAS DEC | CENDENT (| OF HISPANI | IC ORIGIN? (S | pecify Yes | or No- | 14. RACI Blaci | E — American I | ndlen, |
| B | | 3 Nidowed 4 Divorced | | IF YES, GIVE V | | | | | 2 X NO | | | ,,, | | Spec | My: | |
| | - 10 | of money 4 Director | | | | | | | | | | | | 1 | White | e |
| COMPLETED | | 15. DECEDENT (Specify only highes | 'S EDUCAT | TION moleted) | | | USUAL OC | | | 200 | 16b. KJA | OF BUS | INESS/IN | DUSTRY | | |
| | | Elementary/Secondary (0-12) | -i | College (1-4 or 5 | +) ## | e. Do NOT u | se retired.) | | | riv. | | | | | | |
| ຺຺຺຺຺ | | | | | F | actor | y Wo | rkei | r | | East | tern | Igni | ition | Produ | cts |
| S | | 17. FATHER'S NAME (First, Middle, Li | nst) | - | | | | | 18. MOT | HER'S NAM | AE (First, Middl | in Mairian | Sumamal | | | |
| | | | ody | | | | | Baref | | , | | | | | | |
| BE | | 19a. INFORMANT'S NAME (Type/Prin | | - One | | | | _ | | | | | • | | | |
| ဥ | | | | | | | | | | | oute Number, (| | | | | |
| - | Nancy Lesniewski | | | | | 09 - | S. M | arı | yn A | Avenue Baltimore, Ma | | | | , Mai | cyland | 21221 |
| | | 20e. METHOD OF DISPOSITION 1X Burlel 2 Cremetion 3 | Ramova | el from State | 20b. PLACE | ANDDATE | OFDISPOSI | SPOSITION (Name of | | | DATE | 20c. LO | CATION - | N — City or Town, State | | |
| | ı | 4 Donation 5 Other (Specifi | | ar from State | _ Glen | en Haven Memor | | | rial Park 9/9 | | | G16 | n Bu | ırnie | , Mary | land |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | | | 22. N | IAME A | ND ADDRE | SS OF FAC | HLITY | | | | | 20110 |
| | 1 | 100 | 0 | (24 | 1 | N 122 | | | | | e Fun | | | | | |
| | _ | CIVU | lar | 04 | you | e | 40 | 01 | Ritch | hie H | lwy. | Balt: | imor | e, Mo | 1. 2122 | 25 |
| | | 23. PART i. Entar the disease | a, or con | mplications the | t caused the d | eath. Do | not anter | tha mo | oda of dy | ing, such | aa cardiac | or reapi | ratory as | rest, | Approx | |
| | ı | ahock, or heart fa | illure. Lis | st Dnly Dna Cau | ise Dn aach lin | a. | | | | | | | | | | Between and Death |
| | ı | iMMEDIATE CAUSE (Final disease or condition | | RESPIR | A-TORY | FAI LUI | RE | | | | | | | | Oliset i | IIIG CHARII |
| 1 | H | resulting in death) | 8,_ | | | | | | | | | | | | | |
| | | | | | (OR AS A CONSE | | , | 77.0 | | | | | | | | |
| 18 | ı | Sequentially list conditions, | b | | E POLMO | _ | | ANON | J | | | | | | | |
| CERTIFICATION | - | If any, leading to immediate | | | (OR AS A CONSE | | | A A | WARY DISTASE | | | | | | | |
| 1 2 | | CAUSE (Disease Dr Injury | C | | OBSTRUC | | | DUA | Hey I | DIZEN. | 76 | | | | | |
| l 는 | | that initiated events | | DUE TO | (OR AS A CONSE | OUENCE O | F): | | | | | | | | | |
| | | reaulting in death) LAST | d. | | | | | | | | | | | | | |
| | ı | DART II Other alcultiness and | -Ala I | | | | | | | | | | | | | |
| EDICAL | ı | PART II. Other aignificant con | nditiona d | contributing to | death but not | reaulting | in the und | dariyin | g cause | given in i | Part i. 24 | PERFOR | | 24b | . WERE AUTOPS AMAILABLE PRI | |
|] 응 | | | | | | | | _ | | | 1 | YES 2 | □ NO | | COMPLETION (| |
| | 1 | | | | | | | | | | | | | | 1 YES 2 | V/NO |
| 2 | ı | DID TOBACCO U | SE CC | ONTRIBUTE | TO CALL | SE OF | DEAT | H | VES IT | NO | | | | | 1 123 2 | - NO |
| PHYSICIAN: | | 25. WAS CASE REFERRED TO MEDI | _ | SITIKIDOTI | . TO CAU | 3L 01 | DEAT | _ | | | | | | | | |
| 2 | ı | EXAMINER? | Н | HOSPITAL: | | | OTHER | | LACE OF D | DEATH (Che | ck only one) | | | | | |
| YS. | Ш | 1 YES 2 NO | 1 | ☑ Inpetient 2 | ER/Outpatient | 3 🗆 00A | | | ne 5 🗆 Re | esidence (| 6 Other (Sp | pecify) | | | | |
| 품 | | 27. MANNER OF DEATH | | 26a. DATE OF (Month, D | | 28b. TIM | IE OF JURY | 28c. IN. | JURY AT DRK? | | 26d, DESCRI | BE HOW I | NJURY OC | CURED | | |
| BY | | 1 Netural 5 Pending 2 Accident Investig | | | ,, | 1 | М | | YES 2 | □ NO | | | | | | - 1 |
| | ı | 3 Suicide 6 Could | | 28e. PLACE C | F INJURY — At h | ome, ferm, | atreet, facto | ry, offic | :0 | | 28f. LOCATIO | N (Street a | nd Numbe | or Rural I | Route Number, | |
| 18 | J | 4 Homicide determi | | building, | atc. (Specify) | | | | | - 1 | City or To | wn, State) | | | | - 1 |
| 1 | h | 29e. CERTIFIER | | | | | | _ | | | | | | | | |
| PMP | | (Check only | | | | | | | | | | | | | | |
| | 4 | one) 2 MEDICAL EX | (AMINER: | On the besis of e | xamination end/or | Investigation | on, in my of | oinlon, o | death occu | rad at the t | time, data and | place, an | d due to t | he cause(| and manner a | e stated. |
| 0 | 1 | 29b. SIGNATURE AND TITLE OF CE | RTIFIER | | | t | | | 29c. LIC | ENSE NUM | BER | | 29d. DA | TE SIGNED | (Month, Day, Ye | er) |
| BE | | EUGENIO F VII | VES | MD. | Vill | UL | | | 7.74 | | | | | 16 | | |
| 0 | 1 | 30. NAME AND ADDRESS OF PERS | ON WHO O | COMPLETED CALL | SE OF DEATH (IT | M 27 /3- | Drint1 | | | | | | | 100 | - 1 | |
| 1 | | EUGENIO F. VINE | | | | | | 2 5 | T. 6 | BALTI | MORE | | | | | |
| | 1 | 31. DATE FILED (Month, Day, Year) | 7 100 | - | R'S SIGNATURE | | | _ | | | 5.700 | 4 | | | | |
| | | 31. DATE FILED (Month Day Year) 7 1994 Juni Sandar R | | | | | | | | | | | | | | |

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| S, P.O. | death |
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| DIVISION OF VITAL RECORDS, | aw requires that the death certify |
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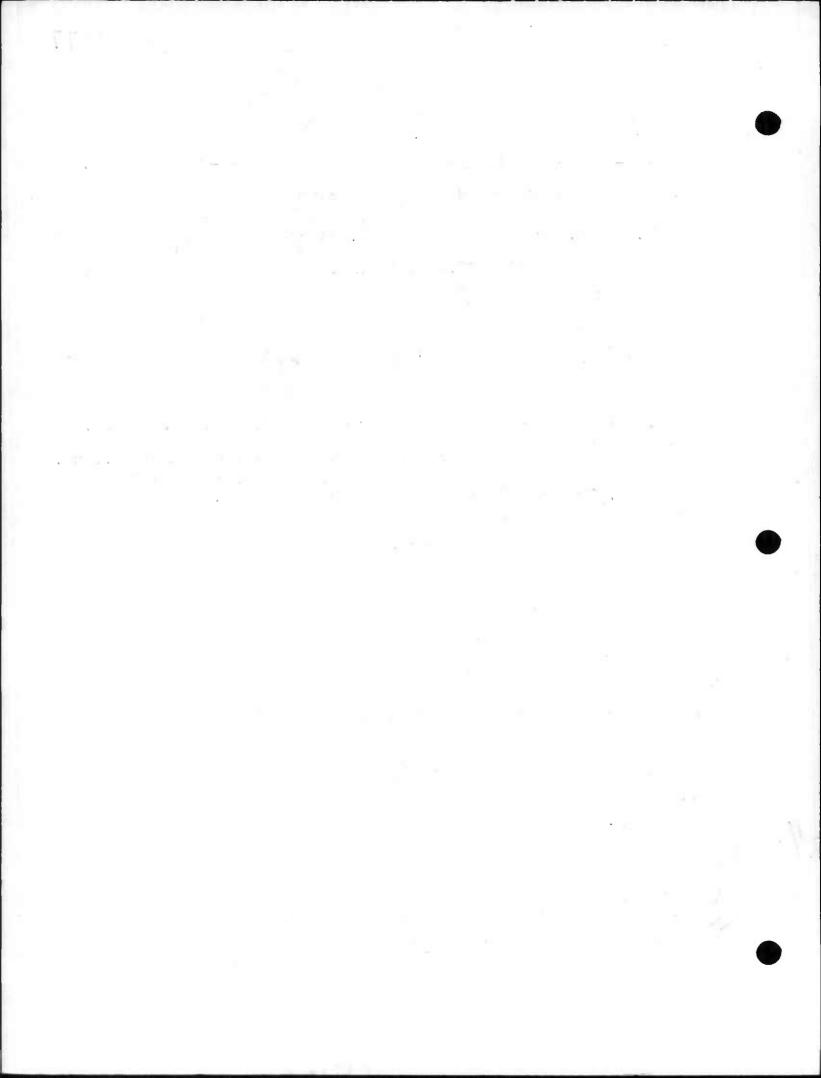
| | REGISTRAR | | | CATE OF DEATH | REG. N | 0. | | | | | |
|---------------|--|--|--|--|--|-------------------------------|---|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last | Helen DV. | Doyle | | 2. DATE OF DEATH MONTH | DAY 9 | YEAR 435 | | | | |
| | 4. SOCIAL SECURITY NUMBER 215-30-0548 | 5. SEX 8. AGE 1 M 2 XF | | IF UNDER 1 YEAR IF UNDER 24 HRS. AONTHS DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 8, 22, | 1906 | BIRTHPLACE (State or Fore Country) Md. | | | | |
| TOR | 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | | | | |
| DIRECTOR | 10a. STATE 10b. COUN | ltimore | 10c. CITY, | TOWN OR LOCATION Catonsville | | | 10d. INSIDE CITY LIMITS? 1 YES 2 KN | | | | |
| FUNERAL | 100. STREET AND NUMBER 715 Maiden Choice | ce Lane | | 101. ZIP CODE 21228 | 100 | | U.S.A. | | | | |
| BY FU | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YES | S 2 NO | 13. WAS DECENDENT OF HISP, if yes, specify Cuban, Maxic 1 TYES 2 NO Specify NO Specify No Specify N | can, Puerto Rican, etc.) | fea or No- 1 | 4. RACE — American Indian, Black, White, etc. Specify: White | | | | |
| TED | 15. DECEDENT'S ED (Specify only highest gra | | 16a. DECEDENT'S U | ork done during most of working | 18b. KIND OF E | USINESS/INDU | STRY | | | | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+) | Secretar | | March | of Dim | es | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) Emmanuel | Schin | dler | 18. MOTHER'S N | AME (First, Middle, Maid | on Surnamo) Schuhma | nn | | | | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING A | ADDRESS (Street and Number or Rura | | | | | | | |
| - | Mr. Robert G. D | 1 | | - J | Luthervill | | | | | | |
| | 20a. METHOD OF DISPOSITION 1 [XBurlal 2] Cremation 3] Ra 4] Donation 5] Other (Specify) | movel from State | Ob. PLACE AND DATE OF emetery, crematory or other | er place) | | | ty or Town, Stata | | | | |
| | 4 Donation 5 Other (Specify) | | | | | | | | | | |
| | 200 | - ADD. | | Ruck Towson 1050 York Rd | | | | | | | |
| CERTIFICATION | reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury CAUSE (Disease or injury | | | | | | | | | | |
| ERTIF | that initieted events resulting in death) LAST | d | A CONSEQUENCE OF): | | | | | | | | |
| MEDICAL | PART II. Other algorificent condition | one contributing to deeth | but not resulting in | the underlying cause given in | | AN AUTOPSY ORMED? 2 100 | 24b. WERE AUTOPSY FIN AMAILABLE PRIOR T COMPLETION OF CA OF DEATH? | | | | |
| CIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 26. PLACE OF DEATH (C | Check only one) | | | | | | |
| SI | 1 ☐ YES 2 NO | 1 Inpatient 2 ER/Ou | utpatient 3 DOA 4 | OTHER: Windling Home 5 Residence OF 28c. INJURY AT | | | | | | | |
| Ž | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident investigation | 28d. DESCRIBE HON | RIBE HOW INJURY OCCURED | | | | | | | | |
| ETED | 3 Sulcide 8 Could not be detarmined 28a. PLACE OF INJURY — At home, farm, street, factory, office 28f. LOCATION (Street and Number or Rural Route of City or Town, State) | | | | | | | | | | |
| COMPLE | | | | at the time, data and place, and do | | | | | | | |
| TO BE (| 20b. SIGNATURE AND TITLE OF CERTIF | EA RIP | | D74 | | | SIGNED (Month, Day, Year) | | | | |
| F | 30. NAME AND ADDRESS OF PERSON V | WHO COMPLETED CAUSE OF E | DEATH (ITEM 27) (Type, F | Maida C | hodee | 199-0 | 2122 8 | | | | |
| | 31. DATE FILED (MONING) DAY COM | 32, REGISTRAR'S SIG | GNATURE | | | | 0 | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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| | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | | ENT OF HEALTH AI | | | | | | |
| 8 | t. DECEDENT'S NAME (First, Middle, Last) ATHER | WE D | DIAI | NGELD | 2. DATE OF DEATH MONTH | DAY 9 9 YEAR | 3. TIME OF DEATH | | | |
| | 4. SOCIAL SECURITY NUMBER 215-24-6798 | 1 DM 2 7 F | 5 YRS. MON | | (Month, Day, Year) 2-5-29 | Cor | HTHPLACE (State or Foreign unitry) Md | | | |
| стов | 96. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DEATH 96. COUNTY OF DEATH HOWARD County General Hospital Columbia Howard County General Howard County General Hospital Columbia | | | | | | | | | |
| L DIRECTOR | Md. Howaj | Lea- citizen o | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | | | | | |
| BY FUNERAL | 16404 01d Free 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | derick Rd 12. WAS DECEDENT EVER IN FORCES? 11 STEP STATE OF THE S | U.S. ARMED 2 NO | S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. RACE — 17. NO 11. yes, specify Cuben, Maxicen, Puarlo Rican, stc.) 14. RACE — 18. RACE — 18. RACE — 19. | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use reti | done during most of working red.) | | USINESS/INDUSTRY | 7 | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | N/A | Retired | | S NAME (First, Middle, Meide | | Store | | | |
| TO BE | Paul Thorn 19a. INFORMANT'S NAME (Type/Print) Mr. Marion Di Ar | ngel o | | RESS (Street and Number or I | | wn, State, Zip Code) | | | | |
| | Mr. Marion DiAngelo 20e. METHOD OF DISPOSITION 1 Touristic 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 16404 Old Frederick Rd. —Mt. Airy Md. 21771 20b. PLACE AND DATE OF DISPOSITION (Name of commettery, cramatory or other place) Crestlawn Cemetery. 9—2—94 Howard Co. Md. | | | | | | | | | |
| in | 21. SIGNATURE OF FUNERAL SERVICE LICE G. Trumar | ensee 1 Schwab | | 5151 Ba] | timore Na | tional: | Pike | | | |
| | 23. PART I. Enter the diseases, or consher tellure. L | | ch line. | nter tha moda of dying, | such ss cardiac or res | piratory arrest, | Approximata Interval Between Onset and Death | | | |
| CERTIFICATION | Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PREFORMED? 1 VES NO 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO | | | | | | | | | |
| ICIAN: | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | | |
| | 1 VES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending | 28e. DATE DF INJURY (Month, Day, Year) | 26b. TIME OF INJURY | Nursing Home 5 Reside | 26d. DESCRIBE HOW | INJURY OCCURED | • | | | |
| TED BY | 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined | 26e. PLACE OF INJURY building, etc. (Speci | NJURY — At home, term, atreet, factory, office | | 281. LOCATION (Street | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| OMPLET | anal . | CIAN: To the best of my knowled: On the basis of axaminstion | | | | | se(a) and manner as stated. | | | |
| TO BE | 296. SIGNATURE AND TITLE OF CERTIFIER | | | 29c. LICENS | | 29d. DATE SIGN | AED (Month, Day, Year) | | | |
| F | JUNAMERAND ADDRESS OF PERSON WHO | 11055 Little | PATHEEOT | Pty Colum | 866 60 ms | 2109 | 14 | | | |
| | SEP 0 7 1994 | 32. REGISTRAR'S SIGNA | TURE | | | | | | | |



DIRECTOR

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CERTIFICATION

MEDICAL

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use as the burial-transit permit. Pages 1, 2, 3 should the hospital or attending physician. n by the funeral director, page 5 should be detached for removal. TO Page 6 may be retained by notified pe must examiner within 24 hours after death. medical filled in by t 6 event, the cremation, completely executed bunal. traumatic and attending physician a antal Hygiene prior to 2 other t 6 the death been signed by the atter t. of Health and Mental Injury, requires that any 23 shows has be Dept. Hem certificate h PHYSICIAN: the 5 with t is marked, After th ATTENDING DIRECTOR: /
hours after o OR TO THE HOSPITAL OF THE FUNERAL COME FIRED WITHIN 72 IN IMPORTANT: If II

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH _ MONTH 3. TIME OF DEATH august 10:30 EMMA DEHAVEN 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign Country) MONTHS DAYS HOURS MIN 1 M 2 ... YRS 07/06/1909 Maryland 218-05-1300 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH UNION N MEMORIAL HOSPITAL BALTIMORE CITY 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 AYES 2 NO Baltimore Maryland 10e. STREET AND NUMBER 10g CITIZEN OF WHAT COUNTRY? USA 3630 Elm Avenue 21211 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuben, Mexican, Puerto Rican, atc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 1 Never Merried 2 Merried 2X 100 1 TYES TO NO Specify: Specify 3 🕅 Widowed 4 🗌 Divorced White 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Homemaker 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Adelaide Spangler Jacob N. Baker 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3630 Elm Avenue, Baltimore, Maryland Mamie E. Walker 20e. METHOD OF DISPOSITION 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 1 XBurlel 2 Cremetton 3 Removal from State
4 Donetton 5 Other (Specify) Emetery, cremetory or other place)
Lorraine Park Cemetery9/3 Woodlawn, Mar yland 21. SIGNATURE OF PUNERAL SERVICE LICENSEE Buttower Heffs Sur Funeral Home 3631 Falls Road, Baltimore, Maryland Im 23. PART I. Entry the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Heart resulting in death) DUE TO (OR AS A CONSEQUENCE OF Sequentially list conditions, DUE TO (DR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 THO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO INCERTAIN IN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 ND 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the besis of exemination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(s) end manner as stated. 29d. DATE SIGNED (Month, Day, Year) №98-31-94 ML18451

6903 Jones View Pr#3B Baltimore, MD 21209

| BALTIMORE, MARYLAND 21203-3146 | be retained by the hospital or attending physician. | The Triber this certificate has been signed by the attending physician and completery Med in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
|--|--|--|
| BALTIMORE | July after death. Page 6 may | ited in by the funeral director, por nemoval. |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | D. ITTENDING PHYSICIAN: The law requires that the death certificate be executed with: Just after death. Page 6 may be retained by the hospital or attending physician. | icate has been signed by the attending physician and completery in State Dept. of Health and Mental Hygiene prior to burial, crematio |
| INISION OF V | O TENDING PHYSICIAL | HE TOR: After this certif |

notified at

28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be

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| | ITEMS: 27,28a-f, PER | MEO FILM G-726 8/2 | 4/95 t | .t | | | , | 7 4 | .0013 |
|----------------------|--|---|---|--|---------------------------|---|--|-------------|---|
| | 1 - STATE REGISTRAR | STATE OF MARYLAND / | | TMENT OF | | MENTAL HYGIE | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | Footer | 'de | en For | salu | 2. DATE OF DEATH | | EAR 3. T | IME OF DEATH |
| JR. | 4. SOCIAL SECURITY NUMBER 218 - 22 - 5663 90. FACILITY NAME (if not institution, give str | treet and number) YRS. MONTHS DAYS HOURS MIN. (Month) 9b. CITY, TOWN OR LOCATION OF DEATH | | | | | ATE OF BIRTH Annth, Day, Year) 7 124 08 Se. COUNTY OF DEATH 8 A 14 A | | |
| DIRECTOR | RESIDENCE OF DECEDENT 106. STATE 10b. COUNTY | CARROLL | 10c. CIT | Y, TOWN OR LOCA | | | | 10d. | INSIDE CITY LIMITS? YES 2 NO |
| FUNERAL | 10% STREET AND NUMBER | - toad | | | | 1157 | 10g. CITIZEN | 15/ | 4 |
| B¥ | 11. MARITAL STATUS 1. Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. AF FORCES? 1 YES 2 SE IF YES, GIVE WAR OR DATES | | If yes, s | | ANIC ORIGIN? (Specify Yean, Puerto Rican, atc.) ify: | es or No- 14. | Specify: | imericen Indien, ite, atc. |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) | completed) (G | ECEDENT'S Give kind of to Do NOT ut | USUAL OCCUPAT work done during in se retired.) | ION oat of working | 16b. KIND OF B | USINESS/INOUST | TRY | • |
| BE | 17. FATHER'S NAME (First, Middle, Last) RALPH FOWL 198. INFORMANT'S NAME (Type/Print) | SR III | b. MAILING | ADDRESS (Street | Con. | AME (First, Middle, Maide | TIKW | lock | alask |
| D | ROSKT FOWLS 20s, METHOD OF DISPOSITION Surfel 2 Cremation 3 Remo 4 Donation 5 Other (Specify) | val from State 20b. PLACE other p | OF DISPO | SITION (Name of co | metery, cremetory or | PARKY 200. L | OCATION I CHY | OF TOWN, S | LAND |
| | 21. SIGNIN UNE OF FUNERAL SERVICE LICE | INSTIT | | 22. NAME / 2VA (880 | ND ADDRESS OF S S CHAR | RO ROAC | wries -Parl | KV.J | 5 |
| | 23. PART I. Enter the diseases, or conshock, or heart failure. LIMMEDIATE CAUSE (Final disease or condition resulting in death) | DUE TO (OR AS A CONSE | ·, hy | fection | | 4 | ery) | , | Approximate Interval Between Onset and Death Lucky |
| ERTIFICATION | Sequantially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | OUE TO (OR AS A CONSE | | | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other significant conditions | contributing to death but not | resulting | In the underlyl | ng cause given i | | NAUTOPSY DRMED? | CON OF E | RE AUTOPSY FINDINGS RABLE PRIOR TO RPLETION OF CAUSE DEATH? YES 2 10 |
| IYSICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? t YES 2 NO 27. MANNER OF DEATH | HOSPITAL: 1 Inpatient 2 ER/Outpatient : | | OTHER: | | 6 Other (Specify) | | | |
| 급 | AT MANNER OF DEATH | (Month, Day, Year) | 26b. TIN | | IJURY AT ORK? | 28d. DESCRIBE HOV | INJUHY OCCUR | ÆD. | |

1 Natural AUG. 8, 1994 2 XAccident 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, stc. (Specify) 3 Sulcide Could not be 4 Homicide HOME

28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 XHO 7 A M FELL DOWN STEPS 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
SAME AS # 10

1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated.

Osler

(Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(e) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year)

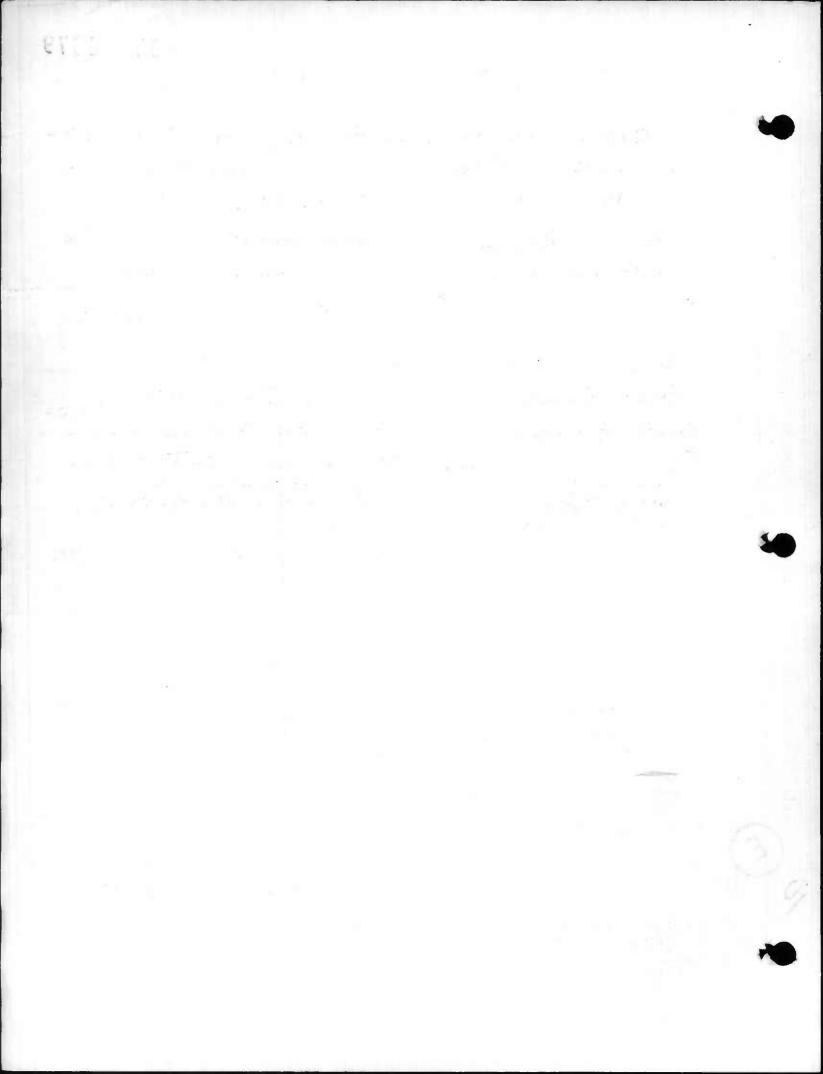
DRNY

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| | ACCRECA OF BERNON! | | | _ |

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7401 Josep 32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and more relative to the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPART | MENT OF H | EALTH AND N | MENTAL HYGIEN | E | | |
|------------------|--|--|-------------------------|-----------------------|-----------------------------|----------------------------------|---------------------|----------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH MONTH DA | | | TIME OF DEATN |
| | ESTHERENE | D. | I | FOSTER | | Sept. 4 | | 94 | n/a M |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. last birthday) | F UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH | 6. | BIRTHPLA Country) | NCE (State or Foreign |
| | 217-56-6185 | _ ~ | 11101 | | | O(Month. Day 1604) 9 | 50 M | aryl | and |
| œ | 9e. FACILITY NAME (If not institution, give str | | | | R LOCATION OF DE | ATN | 9c. COUNTY OF DEATN | | |
| DIRECTOR | 2421 E. Chase Stre | eet | | Baltim | ore | | N, | /A | |
| JE | 10e. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LOCATE | ON | | | 10 | d. INSIDE CITY |
| | MD N/A | | Balt | timore | | | | 11 | LIMITS? |
| FUNERAL | 10e. STREET AND NUMBER | | | 101. | ZIP CODE | | 10g. CITIZEN | OF WHA | T COUNTRY? |
| Ä | 2421 E. Chase St | reet | | | 21213 | | US | SA | |
| J. | 11. MARITAL STATUS 1 Never Merried 2 Merried | 12. WAS DECEDENT EVER IN FORCES? 1 YES | N U.S. ARMED | | | IC ORIGIN? (Specify Yes | or No- 14. | RACE - | American Indian, |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR D | | | NO Specify | | | Specify: | |
| | 15. DECEDENT'S EDUCA | ATION | 18a. DECEDENT'S U | I ISUAL OCCUPATION | N . | 16b. KIND OF BUS | INESS/INDI IS: | | Black |
| ET | (Specify only highest grade c Elementary/Secondary (0-12) | completed) College (1-4 or 5+) | (Give kind of wo | ork done during mos | t of working | IGE. KIND OF BOS | INC33/INDUS | Iny | |
| AP. | 12th | N/A | N/i | A | | N/ | 'A | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S NAM | ME (First, Middle, Melden | Surname) | _ | |
| BE (| James Dorsey | | | | Armst | ella Byrd | | | |
| 6 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | DDRESS (Street an | d Number or Rural R | loute Number, City or Town | , State, Zip Co | de) | |
| - | Armstella Dorsey | | 1737 N | Bradfo | rd Stree | t/Baltimor | e, Mai | cylar | nd 21213 |
| | 20e, METHOD OF DISPOSITION 1 X X Yeurlel 2 Cremetion 3 Remove | | BALTIMO | | | | ATION - City | | |
| | 4 Donation 5 Other (Specify) | | BALITMU | | METERY | | ALTIM | UKE | , MD |
| | | ZINI | | | FINERAL. | HOME EAST | | | |
| | 01500 0.0 | Ja Car | | 1110 E | . NORTH | AVE. /BALTI | MORE, | MD : | 21202 |
| | 23. PART I. Enter the diseases, or co ehock, or heert tailure. Li | implications that caused | the death. Do no | t enter the mod | e ot dying, such | as cerdiec or reapli | ratory arrest | , | Approximata Interval Between |
| | IMMEDIATE CAUSE (Final | | | | | | | | Onset and Death |
| | disease or condition resulting in death) | : METASTA | | | معدم | | | | |
| | | DUE TO (OR AS A | CONSEQUENCE OF) | : | | | | | |
| CERTIFICATION | Sequentially liet conditions, b. | DUE TO (OR AS A | CONSEQUENCE OF | | | | | | |
| Ä | if eny, leading to immediate cause. Entar UNDERLYING | | | | | | | | |
| Ē | CAUSE (Diseese or Injury that initieted eventa | DUE TO (OR AS A | CONSEQUENCE OF) | | | | | | |
| F | resulting in deeth) LAST | | | | | | | | |
| | PART II. Other algnificant conditions | contribution to death b | ut not requition in | the underlying | | | | | |
| CAL | THE STATE OF | Contributing to death of | at not resulting in | the underlying | ceuee given in i | Part I. 24n. WAS AN / PERFORI | | AWA | RE AUTOPSY FINDINGS RLABLE PRIOR TO |
| | | | | | | 1 YES 2 | M NO | | MPLETION OF CAUSE DEATH? |
| Σ | DID TOBACCO USE CONTRI | DUITE TO CALICE O | C DEATH VEC | Пиоп | I IN LOCEDITA IN | _ | | 1 [| YES 2 NO |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL | | 26. PLACE OF DEATH | | UNCERTAIN | | | | |
| SIC | | HOSPITAL: | | OTHER: | - ola - | | | | |
| Ŧ | 27. MANNER OF DEATN | 28a. DATE OF INJURY | 28b. TIME | OF 28c. INJU | 5 N Residence | 28d. DESCRIBE NOW IN | JURY OCCUR | ED | |
| ВУ Р | 1 Natural 5 Pending | (Month, Day, Year) | INJUI | | K? S 2 NO | | | | |
| | 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE OF INJURY building, etc. (Spec | - At home, farm, str | eet, factory, offica | | 281. LOCATION (Street a | nd Number or F | Rural Route | Number, |
| | 4 Nomicide determined | Sunding, atc. (Spec | aty) | | 1 | City or Town, State) | | | |
| COMPLETED | 29a. CERTIFIER (Check only 1 CERTIFYING PNYSICI | AN: To the best of my knowl | edge, death occurred | at the time, data a | nd place, and due t | o the cause(s) and man | ner as stated. | | |
| ŏ | | On the basis of examination | | | | | | JUBO(S) BIN | d manner as atated. |
| | 29b. SIGNATURE AND TITLE OF GERTIFIER | | | | 29c. LICENSE NUMI | | 29d. DATE SI | | |
| BE | In it (-my | 15 | | | 1832 | | 1 9 | 16 | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | | | | | | | | |
| | John H. TETTING | MD. Rn 13 | _ | HOPKI- | os Dow | LOUY CTA | 600 N | ٠. ٤٥٥ | HE 84. |
| | 31. DATE FILED (Month, Day, Year) | 32. EGISTARIS SAL | Mall | · · | | | | An | 170 70 |
| | SEP 0 7 1994 8 | Mr. Williams | | | | | | OF | 315 67 |

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BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760. 1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First, Middle, La | efl | | | | | | | | | | | |
|------------------------------------|--|--|--|--|---------------------------|--|-----------------|--|--|--|--|-------------------------|--|
| Þ | The state of the s | aty | | | | | | | 2. DATE O | F DEATH DAY | Y | YEAR | 3. TIME OF DEATH |
| | CHARLES | EDWARD | FANTO | MC | | | | | 9-1 | | 994 | TEAH. | 5:00 F |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (In yrs | . last birthday) | IF UNDER | | IF UNDER | | 7. DATE OF | BIRTH Day, Year) | | | LACE (State or Foreig |
| | 215-30-9522 | 1 🔀 M 2 🗆 F | 59 | YRS. | MONTHS | DAYS | HOURS | MIN. | 10- | 14-1 | 934 | Ma Ma | ryland |
| 1 | Se. FACILITY NAME (If not institution, gi | e street and number) | | | 9b. CITY, | , TOWN (| OR LOCATION | ON OF DE | | T | | NTY OF DEA | |
| E | 100 Rochester | Place | | | Ba | 1 t.i | imor | 9 | | | | | _ |
| ECTOR | RESIDENCE OF DECEDENT | | | - | | | | | | 1 | | | |
| H | 10a. STATE 10b. COU | NTY | | 10c. CI1 | TY, TOWN C | OR LOCAT | TION | | | | | 1 | IOd. INSIDE CITY LIMITS? |
| DIR | Md | | | В | alti | mor | re | | | | | 1 | YES 2 NO |
| ERAL | 10e. STREET AND NUMBER | | | | | 10 | 1. ZIP CODI | E | | | 10g. CITI | ZEN OF WH | AT COUNTRY? |
| E 1 | 100 Rochester | Place | | | | | | 2122 | 24 | | U.S | . A. | |
| FUN | 11. MARITAL STATUS | 12. WAS DECEDE | | | 13. | WAS DEC | CENDENT C | F HISPAN | IC ORIGIN? | (Specify Year | or No- | 14. RACE - | - American Indian, |
| BY F | 1 Never Married 2 Married | IF YES, GIVE | YES 25 | X NO | | | 2 GNO | | n, Puerto Ric | an, etc.) | | Specify: | White, etc. |
| | 3 X Widowed 4 □ Divorced | | | | | | X | | | | | Whi | te |
| E | 15. DECEDENT'S E (Specify only highest gi | | 16a. | . DECEDENT'S | | | | 107 | 16b. K | IND OF BUSI | INESS/IND | USTRY | |
| | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | life. Do NOT u | ise retired.) | | | • | | | | | |
| N N | 10th | | | Car | pent | er | 2 | | Co | nstr | uct | ion | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTE | HER'S NAI | ME (First, Mic | idle, Malden S | Surname) | | |
| ш | Richard Brise | on | | | | | Do | rot | hy W | . Bil | l1me | yer | |
| 0 8 | 19a. INFORMANT'S NAME (Type/Print) | | | 19b. MAILING | ADDRESS | S (Street a | and Number | or Rural F | loute Number | City or Town | , State, Zip | Code) | |
| F | Paul Koermei | Jr. | | 223 | 2 Gr | avt | chor | n Ro | d. , Ba | ilto. | .Md | . 21 | 220 |
| | 20a. METHOD OF DISPOSITION | | | CE AND DATE | OF DISPOS | | | | DATE | | | City or Town | |
| | 1 Donation 5 Other (Specify) | amoval from Stata | | cometory or o | | | como | +027 | . 0 | 0 | 1 1 | D - 1 + | o.Md. |
| ٥ | 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE | | | 22. | NAME A | ND ADDRES | SS OF FAC | CILITY | | | | |
| | D 11000 | AK.Ph | illip | STac | KS M | fora | an-A | shto | on Fu | nera | 1 H | ome, | 21224 |
| - 8 | Tilled | | | | | | | | | | | | |
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| | shock, Dr heart fallu | a | at caused tha | death. Do | not enter | the mo | E . | BA1t | cimol | e St | ratory arr | alto | Approximate interval Betwoonset and D |
| ATION | immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate | a | at caused that use Dn each | death. Do line. ASA NSEOUENCE O | not enter | the mo | E . | BA1t | cimol | c or reapir | ratory arr | alto | Approximate interval Bett Onset and D |
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| AL CERTIFICATION | shock, pr heart failured in the second in th | a | at caused that use Dri each O (OR AS A COND) O (OR AS A COND) O (OR AS A COND) | ASA A SEQUENCE O | I30 not enter | the mo | E | BA1ting, auct | cimor n aa cardla ARC1 | CE St. | AUTOPSY | alto | Approximate Interval Bets Onset and D |
| | shock, or heart failured in the state of the | a | at caused that use Dri each O (OR AS A COND) O (OR AS A COND) O (OR AS A COND) | ASA A SEQUENCE O | I30 not enter | the mo | E | BA1ting, auct | TIMO) A se cardie ACCI Part I. 2 | CE St. CO reapir NOW A4a. WAS AN APPERFORM | AUTOPSY MED? | 246. V | Approximate Interval Bets Onset and E Onse |
| EDICAL | shock, or heart failured in the state of the | a | at caused that use Dri each O (OR AS A COND) O (OR AS A COND) O (OR AS A COND) | ASA A SEQUENCE O | I30 not enter | the mo | E | BA1ting, auct | TIMO) A se cardie ACCI Part I. 2 | CE St. | AUTOPSY MED? | 24b. V | Approximate Interval Bets Onset and E Onset and E Onset and E ONSET ON THE OWNER OF TOO OF CALOR OF CALOR OF CALOR OF DEATH? |
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a flows after death. Page 6 may be retained by the hospital or attending TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | IAN: The law requires that the death certificate be executed within tificate has been signed by the attending physician and complete he State Dept, of Health and Mental Hygiene prior to burial, crem. | , or item 23 shows any injury, or other traumatic event, the medica |
|---|---|---|
|---|---|---|

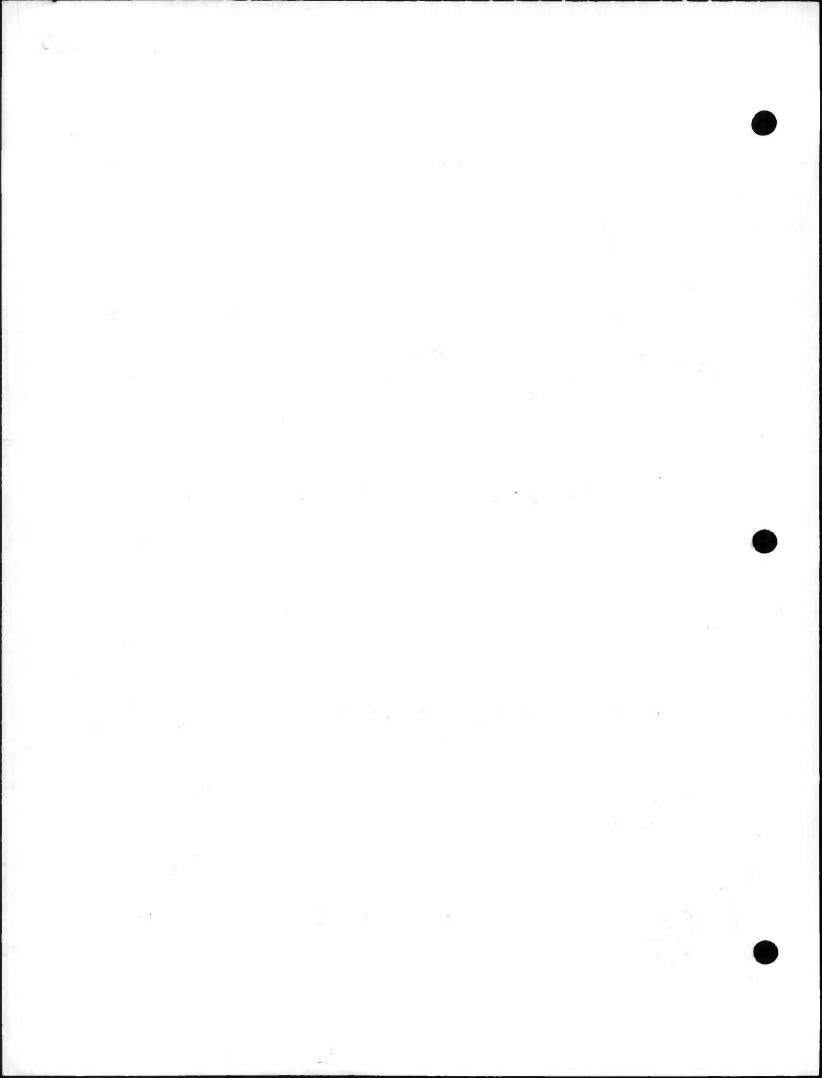
| | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | |
|----------------------|--|---|--|--------------------------------|---|------------------|-------------------------------------|---------------------|------------------------------|---|
| - 2 | 1. DECEDENT'S NAME (First, Middle, Last |) | | | | | OF OEATH | | 3. | TIME OF DEATH |
| | RASHAD | ARON | GROGA | AN | | SE | PT 04 | 1994 | EAR | 8:20 A |
| | 4. SOCIAL SECURITY NUMBER 214-90-1779 | 5. SEX 6. AGE (| | F UNDER 1 YEAR DNTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE | OF BIRTH | 977 M | BIRTHPLA GOUGHTY) ARYL | CE (State or Foreign AND |
| ~ | 9a. FACILITY NAME (If not institution, give | street and number) | 9 | b. CITY, TOWN OR | LOCATION OF DE | | | 9c. COUNTY OF DEATH | | |
| сто | 6215 LIBERTY I | HEIGHTS AVE | NUE | BALTIM | ORE | | | BAI | TIMO | ORE |
| DIRECTOR | MARYLAND 106. COUN | n/a | 10c. CITY, 1 | BALTIM | | | | | 100 | I. INSIDE CITY (LIMITS? YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER 35 30 | MEADOWSIDE | ROAD | 10f. 2 | 21207 | | | UNIT | E D | STATES |
| ВУ | 11. MARITAL STATUS 1XXNever Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IF FORCES? 1 TYES IF YES, GIVE WAR OR O | ≱(XNO | If yes, spec | NOENT OF HISPAR city, Cuban, Maxica ANO Specifi | n, Puerto | N? (Specify Yes Rican, etc.) | or No.— 14 | Black, W Specify: | American Indian, http://dis.atc. |
| COMPLETED | 15. DECEDENT'S ED (Specify only highest grad | | (Give kind of work itte. Do NOT use n STUDE | k done during most etired.) | of working | 168 | n/a | SINESS/INDUS | TRY | |
| BE CON | 17. FATHER'S NAME (First, Middle, Lest) WALTER | W. GROGA | N JR. | | 18. MOTHER'S NA | ME (First | Middle-Meiden | Surname) | | |
| TO B | 198. INFORMANT'S NAME (Type/Print) ARON [| D. SMITH | 3530 | MEADO | WSIDE | R D | , BAL | TSIMOR | É,M |)#07 |
| | 20a. METHOD OF DISPOSITION 1 (2) Puriel 2 Cremetion 3 Rai 4 Donation 5 Other (Specify) | | PLACEAND DATE OF I | | | OAT | E 20c. LO | ANDAL | y or Town, LST(| State OWN, MD |
| | 21. SIGNATURE OF FUNERAL SERVICE L | 3/oll | nel | WM. C | ADDRESS OF FA | H F | | _ | | ORTH AVE |
| | 23. PART I. Enter the diseases, or ahock, or heart fellure iMMEDIATE CAUSE (Final disease or condition resulting in deeth) | a. Gunshot OUE TO (OR AS A | ach iina. | | | | diac or reapi | ratory arrea | t, | Approximate interval Between Onset and Death |
| CERTIFICATION | Sequentially list conditions, if any, laading to immadiate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| PHYSICIAN: MEDICAL (| PART II. Other significant condition | na contributing to death b | ut not rasuiting in t | tha underlying | causa givan in | Part i. | 24a. WAS AN PERFOR | MED? | COL | RE AUTOPSY FINDINGS ILABLE PRIOR TO APLETION OF CAUSE DEATH? |
| N: M | DID TOBACCO USE CONT | TRIBUTE TO CAUSE O | F DEATH YES | | UNCERTAIN | v 🗆 | | | 1 9 | YYES 2 NO |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF OEATH | THER: | | | | | | |
| 1YS | 1 VES 2 NO 27. MANNER OF CEATH | 1 Inpatient 2 ER/Outp | atient 3 DOA 4 | ☐ Nursing Home | 5 Residence | | | | | |
| BY Pł | 1 Natural 5 Pending | (Month, Day, Year) | 28b. TIME O INJUR | Y WOR | RY AT K? S 2 💢 NO | | SCRIBE HOW II | | REO | |
| | 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide datarminad | 28a. PLACE OF INJURY building, atc. (Spec | erry) | et, tactory, offica | | 28t. LOC City | CATION (Street a or Town, State) | nd Number or | DRE 1 | Number, |
| | no. Oppured | | YARD | | | 6215 | HEIGHT | S TERR | ACE | |
| COMPLETED | (Check only | SICIAN: To the best of my knowl IER: On the basis of examination | | | | | | | euse(a) and | I manner as stated. |
| BE C | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | | 29c. LICENSE NUN | | | | | oth, Day, Year) |
| 5 | Alonald & WA | | ATIL (1781) 6 | | O.C.M. | Ε. | | SEP | T.05 | ,1994 |
| | DONALD G. WRI | GHT MD | lll Penn | | t, Bal | timo | ore, M | Maryl | and | 21201 |
| | """ SEP 07 1994 8 | ALL SEPTEMBERS FOR | NAME OF THE PERSON OF THE PERS | | | | | | | |

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760 HISTING OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.

In a hours after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should min a hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | | ENT OF HEALTH AN ATE OF DEATH | | GIENE G. NO. | | | |
|--------------------|---|--|--|------------------------------------|--------------------------|---|--|--|--|
| | 1. DECEOENT'S NAME (First, Middle, Last) | | TE OF BEATT | 2. DATE OF DEATN 3. TIME OF DEATN | | | | | |
| | James GORALS | SKI | | | Septemb | | 994 10:35 PM | | |
| | 4. SOCIAL SECURITY NUMBER | | MON | THE DAYS HOURS ME | RS. 7. DATE OF BIR | TN e | BIRTHPLACE (State or Foreign Country) | | |
| | 215-01-0900 | | 35 YRS. | | 11-11 | -08 M | ARYLAND | | |
| œ | 9a. FACILITY NAME (If not institution, give st FRANKLIN SQUARE | | 96. | CITY, TOWN OR LOCATION O | OF DEATH | | Y OF DEATN | | |
| 5 | RESIDENCE OF DECEDENT | HUSPITAL | | | - | Balt | imore County | | |
| DIRECTOR | 10a. STATE 10b. COUNTY | | | WN OR LOCATION | | | 10d. INSIDE CITY LIMITS? | | |
| | 10e. STREET AND NUMBER | | BALI | IMORE 101, ZIP CODE | | 1 | VES 2 NO | | |
| FUNERAL | 2402 HUDSON STE | REET | | 21224 | | US. | N OF WHAT COUNTRY? | | |
| S | 11. MARITAL STATUS | 12. WAS DECEDENT, EVER IN FORCES? 1 X YES | U.S. ARMEO | 13. WAS DECENDENT OF NE | | olfy Yes or No. 1 | 4. RACE — American Indian, | | |
| BY F | 1 Never Married 2 Married 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR DA | 2 NO | If yes, specify Cuban, Ma | | rtc.) | Black, White, etc. Specify: | | |
| | 15. DECEDENT'S EDUC | ARMY WWII | 18a. DECEDENT'S USU | AL GOODENTION | T 40, 1000 | | WHITE | | |
| COMPLETED | (Specify only highest grade Elementary/Secondary (0-12) | completed) College (1-4 or 5 +) | (Give kind of work life. Do NOT use ret | done during most of working | 160. KIND | OF BUSINESS/INDUS | STRY | | |
| APL | 6 YEARS | Conege (14 til 3 T) | UNIROYAL | | T | IRES | | | |
| Ö | 17. FATHER'S NAME (First, Middle, Last) | / * | | | S NAME (First, Middle, i | | | | |
| BE | ANDREW GORALS | | | LILLI | | ZMNSKI | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) MRS. AGNES SESS | SAMEN | | RESS (Street and Number or R | | or Town, Stete, Zip C | | | |
| | 20a. METHOD OF DISPOSITION | 20h | PLACE AND DATE OF DE | | | Oc. LOCATION — CH | | | |
| | 1 🖄 Buriel 2 🗆 Cremation 3 🗆 Rame 4 🗆 Donation 5 🗆 Other (Specify) | oval from State | etery, cremetory of other to | AUS CEM | | BALTO. | | | |
| | 21 SIGNATURE OF FUNERAL SERVICE LIC | | | 22. NAME AND ADDRESS OF KACZOROWSK | E EACH ITY | | | | |
| | Mayles Xan. | Minude | > | 2525 FLEET | | | . 21224 | | |
| | IMMEDIATE CAUSE (Finel | Arrthymia | ech line. | nter the mode of dying, | auch as cerdlec or | reepiratory arres | Approximate Interval Batween Onset and Death | | |
| _ | _ | | CONSEQUENCE OF): | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | b. Congestive DUE TO (OR AS A | CONSEQUENCE OF): | Lure | | | | | |
| S | ceuse, Entar UNDERLYING CAUSE (Disease or Injury | c | | | | | | | |
| E | that initieted eventa resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | |
| CEF | | i | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other significent condition | e contributing to death be | ut not resulting in th | e underlying cause give | P | VAS AN AUTOPSY PERFORMED? YES 2 XNO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| Σ | DID TOBACCO USE (| CONTRIBUTE TO | CALISE OF D | FATH YES | NO K | | 1 YES 2 NO | | |
| IAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | 26. PLACE OF DEATH | | | | | |
| YSIG | 1 YES 2X NO | HOSPITAL: 1 X Inpatient 2 ER/Outp. | | HER: Nursing Home 5 - Raside | nca 8 - Other (Spec | (fy) | | | |
| PH | 27. MANNER OF DEATH 1 Naturel 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | | NOW INJURY OCCU | RED | | |
| BY | 2 Accident Investigation | 28s BLACE OF MURBY | At home form of | M 1 YES 2 NO | | | | | |
| E COMPLETED | 3 Suicide 8 Could not be 4 Homicide detarmined | 28a, PLACE OF INJURY building, etc. (Spec | — At nome, term, stree | , factory, offica | City or Town | (Street and Number of , State) | r Rural Route Number, | | |
| MPLE | | CIAN: To the best of my knowl | | | | | | | |
| 9 | 29b. SIGNATURE AND TITLE OF CERTIFIER | | and/or investigation, in | | | | cause(a) and manner as stated. | | |
| ₩. | MANCE CO | 1 | | 29c. LICENSE | NUMBER | 1 19d. DATE | SIGNED (Month, Day, Year) | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | O COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type, Prin |) | | 1.110 | 111 | | |
| | Dr. Ritamarie Mosc | | | quare Drive | Baltimore | e, Maryla | and 21237 | | |
| | 31. DATS PIEBP (MODIT! POLYSIS | 32. REGISTRAR'S SIGN | ATURE | | | | | | |
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| VISION OF VITAL RECORDS, P.O. BOX 68/60 | ATTENDIAM DELVE DIAM. The last remained that the stands conficted he excepted with |
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH 3. TIME OF DEATH 10 Sept 6. AGE (In yrs. last birthday) 5. SEX 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTHPLACE (State or Edvalor 1 🖄 M 2 🗌 F Pennsylvania 85 217-20-3786 -12-1909 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Joseph Ritchie Hospice DIRECTOR Baltimore RESIDENCE OF DECEDENT 10a. STATE tob. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Baltimore 1) YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3311 Woodstock Ave. U.S.A. use as the burial-transit 21213 retained by the hospital or attending physician. 5 should be detached for use as the burial-tran 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Noif yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 1 Never Married 2 Married 1 TYES 2 NO Specify: BY White 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) Auto Mechanic Self once. t7. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) George Gain BE Lackner Anna notified page 5 should 198. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Miss Ruth W. Lackner Balto., Md. 21213 Woodstock Ave. Page 6 may be Pe 20s. METHOD OF DISPOSITION
1 M Burial 2 Cremation 3 Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must funeral director. Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Oak Balto. Md. examiner 21. SIGNATURE DE FWHERAL BERVICE LICHNSEE 22. NAME AND ADDRESS OF FACILITY leath. Hartley Miller Funeral Home in by the f Harford Rd. Balto Ad diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, medical 23. PART I. Enter the shock, or heart failure. List only one ceuse on each lina. Interval Between 6 Onset and Death IMMEDIATE CAUSE (Finel the disease or condition RESPIRATORY cremation LREES5 reaulting in death) event. complete DUE TO (OR AS A CONSEQUENCE OF): and con burial, TO LIVER, BONE KARROW Moughs METRSTATIC traumatic CERTIFICATION Sequentielly list conditiona, DUE TO (OR AS A CONSEQUENCE OF): 9 Hygiene pri if any, leading to immediate cause. Enter UNDERLYING -2 Years LUNG OF CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF): thet initiated events the attending p DEPENDENCE resulting in death) LAST NICATINE PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS and AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE OF DEATH? Health a t TYES 2 NO 1 YES 2 NO t. of h has by Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate I tem EXAMINER? HOSPITAL: OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) 1805A1 CZ 1 | Inpatient 2 | ER/Outpetient 3 | DOA 0 23e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED this c marked 1 📳 Netural 5 Pending м 1 YES 2 NO BY After 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be datermined 00 OR ATTEND DIRECTOR: / hours after o COMPLETED 4 🔲 Homicide 28 tem 29s. CERTIFIER (Check only | CERTIFYING | PHYSICIAN: To the best of my knowledge, desth occurred at the time, date end place, and due to the cause(a) and menner as stated. HOSPITAL FUNERAL C TO THE HOSPITA
TO THE FUNERA
be filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) buch un 0 02250 9 4 2

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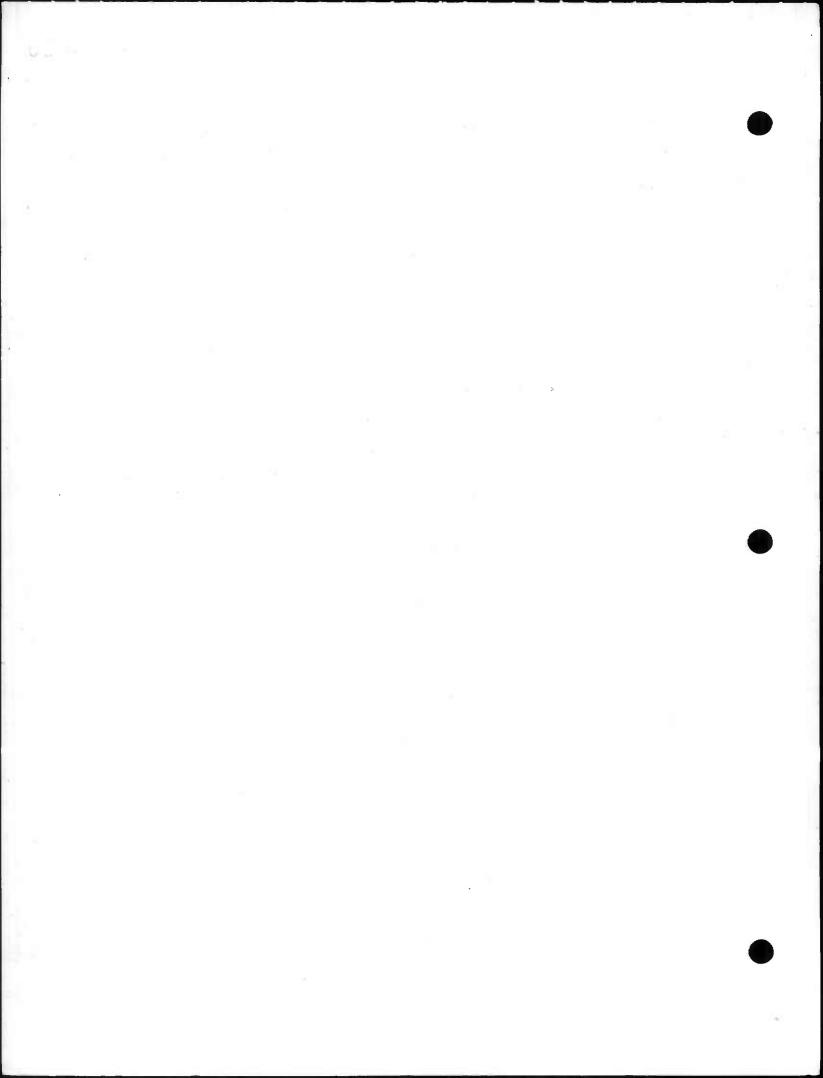
32. REGISTRAR'S SIGNATURE in Sinden-Parkett

SEP 0 7 1994

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

| | 1 - FOR STATE OF MARYLAND / DEPARTMENT / DEPARTMENT / DEPARTMENT / DEPARTMENT / DEPARTMENT / DEP | |
|---------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 2. DATE OF OEATH 3. TIME OF DEATH |
| | Frank R. Garner, III | 9-2-94 YEAR 407 AM |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) F UNDER 1 YI | EAR IF UNDER 24 HRS. 7. DATE OF BIRTH AVS HOURS MIN. (Month) Dipt, Yegr) (1.00) 8. BIRTHPLACE (State or Foreign Quintry) / Quintry) |
| | 210-J2-J407 RAM 2 F 7 YRS. | AVS HOURS WIN. 4-17-191949 Many Land |
| 00 | | OWN OR LOCATION OF DEATH Ltimore |
| DIRECTOR | RESIDENCE OF DECEDENT | t Cmore |
| 35 | 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR L | LOCATION 10d. INSIDE CITY LIMITS? |
| | Md Baltin | nore >1 X yes 2 \(\text{NO}\) |
| 3AL | 10s. STREET AND NUMBER | 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? |
| FUNERAL | 3/2/ Clearview Ave. 11. WARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS | 21234 U.S.A. |
| | 1 Never Merried 2 Married FORCES? 1 YES 2 NO If ye | B DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— be, specify Cuben, Maxican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, atc. |
| BY | 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 | YES 2X NO Specify. White |
| 8 | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18e. DECEDENT'S USUAL OCCU (Give kind of work done durit | JPATION 18b. KIND OF BUSINESS/INDUSTRY |
| COMPLET | Elementary/Secondary (0-12) Collega (1-4 or 5+) life. Do NOT use retired.) Managen | Roofing Co. |
| MP | 17. FATHER'S NAME (First, Middle, Last) | |
| | Frank R. Garner, gr. | 18. MOTHER'S NAME (First, Middle, Meiden Surname) Evelyn F. Spinks |
| BE | 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (SI | Treet and Number or Rural Route Number, City or Yown, State, Zip Code) |
| 임 | Mrs. Susan J. Garner 3121 Clea | arview Ave. Balto., Md. 21234 |
| | 20a. METHOD OF DISPOSITION 1 □ Burlal 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITIO permetery, crematory or other place. | |
| | 4 Donation 5 Other (Specify) Greenmount Cn | remATORY 9/5 Balto., Md. |
| 8 | Down Amith | me and address of faculty artiey Miller Funeral Home |
| | 75 | 12/ Hartord Rd. Balto. Md. 2/234 |
| | 23. PART // Enter two diseases, or complications that caused the death. Do not enter the ahock, or heart failure. List only one cause on each line. | intarval Between |
| | IMMEDIATE CAUSE (Final disease or condition | Pelions 244 |
| 1 1 | resulting in death) a. What are the following in death) OUE TO (OR AS A CONSEQUENCE OF): | recon |
| z | C b | |
| CERTIFICATION | Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING | |
| 일 | CAUSE (Disease or Injury | |
| ᇤ | that initiated evants resulting in death) LAST | İ |
| 1 1 | DADT is Other circuitions conditions conditions | |
| CAL | PART ii. Other algnificant conditions contributing to death but not resulting in the under | PERFORMED? AVAILABLE PRIOR TO |
| MEDIC | | 1 TYES 2 NO COMPLETION OF CAUSE OF DEATH? |
| | | 1 YES 2 NO |
| AA | 25. WAS CASE REFERRED TO MEDICAL | 26. PLACE OF DEATH (Check only one) |
| SIC | EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 MER/Outpetient 3 DOA 4 Nursing | Homa 5 Realdenca 6 Other (Specify) |
| PHYSICIAN: | (Month, Day, Year) INJURY | c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED WORK? |
| ВУ | 2 Accident Investigation M 1 | YES 2 NO |
| 8 | 3 Sulcide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, building, etc. (Specify) | office 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
| | 29e. CERTIFIER | |
| COMPLET | 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, one) | , date and place, end due to the cause(a) and manner as stated. Ion, death occured at the time, date and place, and due to the cause(a) and manner as stated. |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) |
| BE (| Chi Purtell Stock Officer | D14714 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ |
| 임 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | 24.7 |
| | FSIEME 4940 BASTELN AVE 1 | MTI MORE NO 21224 |
| | SEP 0 7 1994 July Sunday | |
| السا | OLI U I IJUT AMPRIMENTATION | |



DIVISION OF VITAL RECORDS, P.O. BOX 68760.

| ter death. Page 6 may be retained by the hospital or attending physician. | is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal. | si examiner must be notified at once. | TO BE COMPLETED BY FUNERAL DIRECTOR |
|--|--|--|--|
| PHYSICIAN: The law requires that the death certificate be executed within thours after death. Page 6 may be retained by the hospital or attending physician. | DIRECTION After this certificate has been signed by the attending physician and completely filled in by the further than the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | In a marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | CENTED BY PHYSICIAN: MEDICAL CERTIFICATION |
| TO THE HOSPITAL | TO THE PUNERAL DIS De filed within 72 has | IMPORTANTAL III | TO BE COMPE |

| | | | | | 24 | 20000 |
|--|---|---|--|---|-----------------|--|
| 1 - STATE REGISTRAR | STATE OF MARYL | | ENT OF HEALTH AND ATE OF DEATH | MENTAL HYGIEN REG. NO | _ | |
| 1. DECEDENT'S NAME (First, Middle, Last | itte E | HANG | LAND | 2. DATE OF DEATH MONTH DO | 6 1994 | 3. TIME OF DEATH 7.05 P |
| 4. SOCIAL SECURITY NUMBER 2 5 0/9 82 | | | UNDER 1 YEAR IF UNDER 24 HRS. ITHIS DAYS HOURS MIN. | 7, DATE OF BIRTN (Month, Day, Year) O1 ~ O3 ~ | Cour | INPLACE (State or Foreign |
| 90. FACILITY NAME (If not Institution, give Good SAMAF | | 96 | BALTIMOR | | 9c. COUNTY OF | |
| 10a. STATE 10b. COUN | LTIMORE | | OWN OR LOCATION | | * | 10d. INSIDE CITY LIMITS? |
| 10e. STREET AND NUMBER | | | 101. ZIP CODE | | | 1 YES 2 NO |
| 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER FORCES? 1 YES | IN U.S. ARMED | 13. WAS DECENDENT OF NISPA If yes, specify Cuban, Mexic | NIC ORIGIN? (Specify Yea an, Puarto Rican, etc.) | or No — 14. RAG | CE — American Indian, eck, White, etc. |
| 3 Widowed 4 Divorced | IF YES, GIVE WAR OR D | | 1 TYES 2 NO Speci | | W | HITE |
| (Specify only highest gra | College (1-4 or 5+) | life. Do NOT use rel | done during most of working ired.) | | SINESS/INDUSTRY | /A V |
| 17. FATHER'S NAME (First, Middle, Last) | | Secreto | 18. MOTHER'S N. | AME (First, Middle, Maiden | Surname) | |
| 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING ADI | DRESS (Street and Number or Rural | Route Number, City or Tow | | |
| Jens Hangland 2445 Springlake Dr. Timen 200. PLACE AND DATE Of DISPOSITION DATE 20c. LOCATION - C | | | | | | |
| 4 Donation 5 Other (Specify) Green Mount Cemetery 79/94 Bout o. Md. 21. SIONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | |
| Relet W | Thousand | | EVANS Chape 2325 York | | | 1. 21093 |
| 23. PART I. Enter the diseases, or shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in desth) | a | pirati | enter the mode of dying, su | ch aa cerdiac or resp | iratory arrest, | Approximate Interval Betwee Onset and Daar |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that Initiated events resulting in death) LAST | b. UGI DUE TO (OR AS: C. Mali | A CONSEQUENCE OF): GONSEQUENCE OF): ACONSEQUENCE OF): | Coffee gn | ourd) | | |
| PART II. Other significant condition | ons contributing to death i | but not resulting in th | ne undarlying cause givan in | Part I. 24e, WAS AN PERFOR | MED? | Ib. WERE AUTOPSY FINDING MARLABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 01 | 28. PLACE OF DEATH (C | heck only one) | | |
| 1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | 1 September 2 ER/Out 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF | | 6 Other (Specify) 28d. DESCRIBE HOW I | NJURY OCCURED | |
| 2 Accident Investigation 3 Suicide 8 Could not b 4 Homicide determined | 28e. PLACE OF INJURY | Y — At home, farm, atrea | | 28f. LOCATION (Street City or Town, State) | | l Route Number, |
| A Secretary of the second seco | | | the time, data and place, and du | | | |
| 29b. SIGNATURE AND THAT OF CERTIF | | 1 | 29c. LICENSE NU | MBER | | (a) and manner as stated. (D (Month, Day, Year) |
| 30. NAME AND ADDRESS OF HERSON W | THO COMPLETED CAUSE OF DE | | | | him over | WN 21120 |
| 31. DATE FILE (MONT) 1994 | 32. REGISTRAR'S SIGN | yATURE! | 1 Newca on | J. Jacob | 111 114 1 | 11/2/23) |

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| | FOR 1 - STATE REGISTRAR | | STATE OF I | | / DEPAI | | | | | MENTA | | E | | |
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| | 1. DECEDENT'S NAME (First | Middle, Last) | | ennis | B. | Haue | | DEA | Н | 2 DATE | REG. NO. | | | 3. TIME OF DEATH |
| | DEMNI | | | / | 2. | THE CHE | 1 | | | MONT | | | YEAR | LIME OF DEATH |
| | 4. SOCIAL SECURITY NUME | | 5. SEX | 6. AGE (In yrs. | last birthday) | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE | OF BIRTH | 197 | A. BIRTH | IPLACE (State or Foreign |
| | 212 36 7 | 281 | 1/2 M 2 🗆 F | 55 | YRS. | MONTHS | DAYS | HOURS | Mine. | Aug | " 5, 19 | 939 | Mar | yland |
| or | Sa. FACILITY NAME (If not in | | · · | | | 111 | | R LOCATI | | EATH | | 9c. COUN | ITY OF D | EATH |
| DIRECTOR | BALTIMON RESIDENCE OF DEC | | 16 | | | 6, | ALT | MOY | 4 | | | | - | |
| E I | 10a. STATE | 10b. COUNTY | | | 10c, CIT | Y, TOWN O | R LOCAT | ION | | - | | | | 10d. INSIDE CITY |
| 1 1 | Maryland | Ba | Ltimore | | 1 | Ess | ex | | | | | | | LIMITS? |
| FUNERAL | 100. STREET AND NUMBER 259 S | | stern Gt | • | • | | 101 | ZIP COD | | | | 10g. CITIZ | ZEN OF V | WHAT COUNTRY? |
| 3 | 11. MARITAL STATUS | | 12. WAS DECEDEN | IT EVER IN U.S. | ARMED | 13. 1 | MAS DEC | ENDENT C | OF HISPAI | VIC ORIGI | N? (Specify Yes | or No | 14. RACE | - American Indian, |
| BY | 1 Never Married 2 5 3 Widowed 4 Divo | | IF YES, GIVE Y | WAR OR DATES | | | | 2 III NO | | | Rican, etc.) | P | Speci | white, etc. White |
| <u>B</u> | 15. DEC (Specify only | EDENT'S EDUCA y highest grade o | ATION ompleted) | | DECEDENT'S | USUAL OC | CUPATIO | N et of workin | | 168 | , KIND OF BUS | SINESS/IND | USTRY | |
| COMPLET | Elementary/Secondary (0 | | College (1-4 or 5 | +) | (Give kind of life. Do NOT u | se retired.) | Jung Mo | st or working | • | | C | ffice | e Su | pply Co. |
| 8 | 17. FATHER'S NAME (First, M | iddle, Last) | | | | | | 16. MOT | HER'S NA | ME (First, | Middle, Maiden | Sumame) | | |
| BE (| | | . Haue | r | | | | | Mary | D. | Rai | dv | | |
| 70 | Adrienne H | auer. W | life | | 196. MAILING 259 | Sout | (Stroot a | nd Number S ter | or Rural | Route Num | ber, Chy or Town | re, State, Zip | (D 2 | 1221 |
| | 20a. METHOD OF DISPOSITI | | 07.75550377 | 20b. PLAC | CE AND DATE | OF DISPOSI | ITION (Ne | me of | _ | OAT | E 20c. LO | CATION — (| City or To | wn, State |
| | 1 Description 5 Description 4 Description 5 Description 5 Description 5 Description 5 Description 1 | (Specify) | 11 | cemelen | C Lawn | the clace) | eter | У | | 9/7/94 Baltimore Co., MD | | | | |
| | 21. SIGNATURE OF POHERA | SERVICE LICE | HSM | | | 22, NAME AND ADDRESS OF FACILITY Bruzdzinski Funeral Home PA | | | | | | | | |
| | Deel ma | 111 | 100 | 2012 | 1 | | | | | | | | • | MD 21221 |
| 1 | 23. PART I. Enter the di shock, or h IMMEDIATE CAUSE (Fin disease or condition resulting in death) | eart failure. Li | ist only one can | OR AS A CON | Ine. | | | | Ing, suc | h as cen | dlec or respi | ratory arm | est, | Approximate interval Between Onset and Death |
| CERTIFICATION | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d | | | | | | | | | | | | | |
| _ | PART II. Other significe | nt conditions | contributing to | deeth but no | t resulting | In the un | derlying | cause (| given in | Part I. | 24s. WAS AN | | 24b. | WERE AUTOPSY FINDINGS |
| MEDICA | | | | | | | | | | | PERFOR | B | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| | | | | | | | | | | | | | | |
| S | 25. WAS CASE REFERRED TO EXAMINER? | _ | HOSPITAL: | | | OTHER | | ACE OF D | EATH (Ch | eck only or | ne) | | | |
| PHYSICIAN: | 1 TES 2 NO | | Sunpatient 2 | | | 4 🗆 Nurs | | 5 🗆 Re | sidence | 6 🗆 Othe | H (Specify) | | | |
| 200 | 27. MANNER OF DEATH 1 Netural 5 | Pending | 28a. DATE OF (Month, D | | 28b. Till | URY | | RK? | | 28d. OE | SCRIBE HOW II | JURY OCC | URED | |
| B | 2 Accident | Investigation | 28e PLACE C | F INJURY — At | home form | atra et Janta | | ES 2 | NO | 201 4 0 0 | | | | |
| LETED | | Could not be determined | building, | atc. (Specify) | nome, raim, | street, recit | ory, office | • | | City | or Town, State) | na Number | or Murai F | loute Number, |
| MIPLE | | | AN: To the best of | | | | | | | | | | |) and manner as stated. |
| Ž | 29b. SIGNATURE AND TITLE | | | | | | | | ENS# NUR | | | | | (Month, Day, Year) |
| B | Kandi | t Li | ~ MD | | | | | | U/A- | | | D 9 | 1/2/ | 194 |
| 5 | 30. NAME AND ADDRESS OF | | COMPLETED CAU | SE OF DEATH (I | TEM 27) (Type | Print) | المعرة | D Desc | 1.05 | Mænid | INE | 555 | 5. 6F | ecule IT |
| | 31. DATE FILED (Month, Day | Year) | / 32. REGISTRA | R'S SIGNATURE | E CA | · Mild | 44.47 | UT | 1.00 | Sall | | BATT | 10,1 | OPEIS AN |
| | SEP 0 7 199 | 14 9 | | Prince | | | | | | | | | | |

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| 1 | 1. DECEDENT'S NAME (First, Middle, Lest) | Percel | CERTIFICA | TIL OF | JEAN | REG. NO | , | 1. TIME OF CHANTH |
|--------------------|---|---|---|--|---|---|--|--|
| | GEORGE | PURCELL | HENDRICK | | | | 4/19 | S. In Dra |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (II | yrs. last birthday) | MDER 1 TEAR | IF UNDER 24 HRS. | 7 DATE OF BIRTH | 7 1 | DOTTHPLACE (State or Foreign |
| | 426-52-4384 | 1 💢 M 2 🗌 F | 72 YRS. | THB DATE | HOURS MIN. | June 18, | 1922 | Mississi |
| _ | 9a. FACILITY NAME (If not institution, give st | | 96. | | H LOCATION OF DE | ATH | 10-10-10-10-10-10-10-10-10-10-10-10-10-1 | Y OF DEATH |
| 5 | 3300 Whitesworth | Rd. | | Pho | enix | | Bal | timore |
| DIRECTOR | 10a. STATE 10b. COUNTY | , | 10c. CITY, TO | WN OR LOCAT | ION | | | 10d, INSIDE CITY |
| | Miss. | Hinds | Jac | kson | | | | LIMITS? |
| FUNERAL | 10e. STREET AND NUMBER | | | 101. | ZIP CODE | | 10g. CITIZE | N OF WHAT COUNTRY? |
| Ä | 775 N. Bierdeman | | | | 9208 | | | .S.A. |
| | 1 Never Married 2 Married | 12. WAS DECEDENT EVER IN FORCES? 12 YES | 2 NO | If yes, spe | city Cuban, Maxicar | IC ORIGIN? (Specify Year, Puerto Rican, etc.) | a or No- | I. RACE — American Indian, Black, White, alc. |
| В | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DA | IES | 1 YES | 2 X NO Specify | : | | Specify: White |
| 딢 | 15. DECEDENT'S EDUC (Specify only highest grade | CATION completed) | 16a. DECEDENT'S USU. (Give kind of work of | AL OCCUPATIO | N it of warking | 16b. KIND OF BU | SINESS/INDUS | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5 +) | life. Do NOT use reti | red.) | • | I | | |
| ME | 17. FATHER'S NAME (First, Middle, Lest) | 4 | State Poli | ce | 40 1007115010 114 | | | tate Police |
| | | endrick | | | Cottie | ME (First, Middle, Maiden Bel | • | Currin |
|) BE | 19a. INFORMANT'S NAME (Type/Print) | CHALLER | 196. MAILING ADD | RESS (Street ar | | oute Number, City or Toy | | |
| 5 | Mrs. Carolyn W. H | eggie | 3300 Wh | iteswo | rth Rd. | Phoenix, | Md. 21 | 131 |
| | 20a. METHOD OF DISPOSITION 1 □XBurlal 2 □ Cremation 3 □ Ramo | 20b. | PLACE AND DATE OF DI | SPOSITION (Na | me of | DATE 20c. LC | CATION CIT | v or Town State |
| | 4 Donation 5 Other (Specify) | Lal | rewood Mem | | | | ackson | , Mississipp |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | | owson Fu | neral Hom | e Inc. | |
| | 23. PART I. Entar the diseases, or c | 24/1/ | - | 1050 Y | ork Rd. | Towson, M | d. 212 | |
| CERTIFICATION | Sequantially list conditions, if arry, laeding to immediata cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in daath) LAST | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A | CONSEQUENCE OF: | l Va mar | sculo | a Dis | ear | 2 |
| 111 | | e underlyino | | Part I. 24a. WAS AM PERFO | NMED? | 24b. WERE AUTOPSY FIND AMALABLE PRIOR TO COMPLETION OF CAU OF DEATH? | | |
| MEDICAL | DID TOBACCO USE CONTR | RIBUTE TO CAUSE OF | Mell DEATH YES [| NO 0 | | _ 1 | | ↑ □ YES 2 □ NO |
| MEDICAL | DID TOBACCO USE CONTR | RIBUTE TO CAUSE OF | DEATH YES [B. PLACE OF DEATH (C) | NO Dect only one) | UNCERTAIN | | | 1 TYES 2 NO |
| SICIAN: MEDICAL | DID TOBACCO USE CONTR | RIBUTE TO CAUSE OF HOSPITAL: Inpetient 2 ERIOUTPE | DEATH YES [B. PLACE OF DEATH (O) THIRM 3 DOA O' 250. TIME OF | NO Descriptions of the North Control of the North C | UNCERTAIN | | NJURY OCCU | |
| PHYSICIAN: MEDICAL | DID TOBACCO USE CONTR 25. WAS CASE RESEMBED TO MEDICAL. EXAMINERY 1 STES 2 NO 27. MANNER OF DEATH 1 NITURE 5 Pending | RIBUTE TO CAUSE OF | DEATH YES [6. PLACE OF DEATH (C) think 3 1 DOA 4 | NO Description No Des | UNCERTAIN | I □ Other (Specify) | NUMY OCCUR | |
| EDICAL | DID TOBACCO USE CONTR 25. WAS CASE RESEMBLE TO MEDICAL. EXAMINERY 1 FAS 2 NO 27. MANNER OF OGATH 1 MINUTES 5 Pending | RIBUTE TO CAUSE OF HOSPITAL: Inpetient 2 ERIOUTPE | DEATH YES [6. PLACE OF DEATH (C) think 3 000 4 000 28b. TIME OF INJURY | NO Description of the second o | UNCERTAIN 5 & Basellince RHY AT RES 2 HO | I □ Other (Specify) | and Number or | nep |

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| BALTIMORE, MARYLAND 21215-002(| a retained by the hospital or attending about |
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| | FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I | MENTAL HYGIE | |
|-----|--------------------------------------|--|------------------|-----|
| D | ECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF OEATH | |
| τ.7 | illiam Danwer H. | ah-n | MONTH | DAY |

| | 1 - STATE REGISTRAR | SIAIE UF N | | ERTIF | | | | | MENTAL HYGI REG. 1 | | | |
|---------------|---|------------------------------|--------------------|----------------------------|-------------|-------------|--------------|-------------|--|----------------------|-------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, La. | et) | | | | | | | 2. DATE OF OEATH | | | 3. TIME OF OEATH |
| | William Henry | Hahn | | | | | | | August 2 | 7 1 Q | YEAR Q / | 9:30 a. M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. le | st birthday) | IF UNDER | R 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF BIRTH | | 6. BIRTH | PLACE (State or Foreign |
| | 219-18-0811 | 1 💢 M 2 🗌 F | 71 | YRS. | MONTHS | DAYS | HOURS | MIN. | Dec. 30, | 1922 | Country | yland |
| | 90. FACILITY NAME (If not institution, give | re street and number) | | | 9b. CITY | , TOWN C | R LOCATIO | ON OF DE | | | UNTY OF DE | - |
| <u>۳</u> | 3728 Elmora Ave | nue | | | Rai | Ltimo | re | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT | | | | | L O ZIII (| - | | | | | |
| Ä | 10e. STATE 10b. COU | NTY | | 10c. CIT | Y, TOWN | OR LOCAT | ION | | | | | 10d. INSIDE CITY LIMITS? |
| | Maryland | | | Ва | altin | nore | | | | | | 1 X YES 2 NO |
| \¥. | 10e. STREET AND NUMBER | | | | | 101 | . ZIP CODE | | | 10g. Cf | TIZEN OF W | HAT COUNTRY? |
| 岁 | 3728 Elmora Ave | nue | | | | | 2121 | .3 | | U. | S.A. | |
| FUNERAL | 11. MARITAL STATUS 1 Never Merried 2 Merried | 12. WAS DECEDEN FORCES? 1 | T EVER IN U.S. AI | RMED | 13. | WAS DEC | ENDENT O | F HISPANI | C ORIGIN? (Specify | Yes or No- | 14. RACE Black | - American Indian, White, etc. |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE W | MAR OR DATES | | | 1 TES | 2 X NO | Specify | ,, | | Specifi | |
| | 15. DECEDENT'S E | | War II | ECEDENT'S | HOUALO | COLIDATIO | NA I | | | | <u> </u> | WILLE |
| COMPLETED | (Specify only highest gro | ade completed) | (0 | Give kind of the Do NOT us | work done | during mo | st of workin | g | 16b. KIND OF | BUSINESS/IN | IDUSTRY | |
| P.E | Elementary/Secondary (0-12) N/A | College (1-4 or 5 d | •) | te Se | 11777 | | | | Stoo | 1 Com | Danii | |
| W | 17. FATHER'S NAME (First, Middle, Last) | 11/21 | Ka | ice be | ccci | | 18 MOTE | ED'C NAS | ME (First, Middle, Maid | _ | | |
| ВC | Charles Hahn | | | | | | | | e Miller | | | |
| 00 | 19e. INFORMANT'S NAME (Type/Print) | | 19 | 9b. MAILING | ADORES | S (Street a | | | oute Number, City or | | in Codes | |
| 일 | Lenora M. Hahn | (Wife) | | | | | | | altimore | | 212 | 13 |
| | 20g. METHOD OF DISPOSITION | - | 20b. PLACE | | | | | , 1 | | LOCATION - | | |
| | 1 X Buriet 2 ☐ Cremetion 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) _ | emoval from State | Park | ramatory or o | ther place) | ters | J | | | | | Maryland |
| | 21, SIGNATURE OF FUNERAL SERVICE | LICENSEE | 7 | | 22. | NAME AN | D ADDRES | S OF FAC | ILITY | | orc, | naryrana |
| | » 11/5/16 | 8/0/ | X | | | | | | eral Hom | _ | | 0.0.0 |
| \vdash | 22 DART I Enter the discourse | Cap | (M) | | 3 | 3331 | Bren | ms L | ane, Bal | timor | e, Md | |
| | 23. PART i. Enter the diseases, c shock, or heart failur | e. List only one cau | ise on each line | a. | nDt anter | the mo | da of dyl | ng, auch | aa cardiac or re | piratory a | rreat, | Approximata Intarval Between |
| | IMMEDIATE CAUSE (Final disease or condition | n. | 0 - | , | 1 | | A = | | | | | Onaat and Daath |
| | resulting in death) | a / / CAL | limen course | of / | | | | | | 8 months | | |
| _ | | A. C. | CON AS A CONSE | EOUENCE O | F): | | | | | | | |
| CERTIFICATION | Sequentially list conditions, | b. DUE TO | (OR AS A CONSE | OUENCE O | E OF): | | | | | | - | |
| ¥ | If any, leading to immediate cause. Enter UNDERLYING | | | | , | | | | | | | İ |
| 트 | CAUSE (Disease or injury that initiated events | DUE TO | (OR AS A CONSE | OUENCE O | F): | | | | | | | 1 |
| ᇤ | reaulting in death) LAST | d. | | | | | | | | | | |
| Ö | DART II Other elemiticant conditi | lana annalbudun an | | L. U.M. S. | | | | | | | | |
| ICAL | PART II. Other algnificant conditi | iona contributing to | death but not | reauiting | in the ur | ndarlying | g cause g | iven in i | PERF | AN AUTOPSY ORMED? | 24b. | WERE AUTOPSY FINDINGS AMILABLE PRIOR TO |
| 👸 | | | | | | | | | 1 □ YES | 2 NO | | COMPLETION OF CAUSE DF DEATH? |
| MED | | | | | | 1 | / | | | | | 1 TES 2 NO |
| HYSICIAN: | DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL | TRIBUTE TO CA | | | | NO 🗵 | UNC | ERTAIN | | | | |
| 힐 | EXAMINER? | HOSPITAL: | | CE OF DEA | OTHE | R: | 5 / | | | | | |
| ¥ | 1 YES 2 NO | 1 Inpetient 2 I | | 3 DOA 28b, TIM | _ | _ | _ | aldence (| Other (Specify) | | | |
| 1 | Natural 5 Pending | (Month, D. | | IN. | IURY M | | RK? | 1 40 | 28d. DESCRIBE HO | V INJURY O | CCURED | |
| 4 | 2 Accident Investigatio | | F INJURY — At he | ome ferm | | | /E\$ 2 _ | NO | and I control (or | | | |
| 2 | 3 Suictde 6 Could not t 4 Homicide determined | building, | etc. (Specify) | ome, term, | street, lac | tory, orner | | | 26f. LOCATION (Stre City or Town, Ste | | er or Runal Ro | oute Number, |
| Ē | 29e. CERTIFIER | | | | | | | | | | | |
| N N | (Check only | YSICIAN: To the best of | | | | | | | | | | |
| COMPLET | 2 MEDICAL EXAM | INER: On the besis of e | xamination end/or | Investigation | on, In my o | opinion, de | eath occur | ed at the t | ime, date end place, | end due to i | lhe ceuse(s) | end menner as stated. |
| BE | 296. SIGNATURE AND TITLE OF CERTIF | | | | | 1 | | NSE NUM | | 29d. DA | TE SIGNED | (Month, Day, Year) |
| 70 | DIVIO | mo | | | | | D | 406 | 09 | | 8/30 | 194 |
| | 30. NAME AND ADDRESS OF PERSON | | | | | (| East | Poi | nt Office | Buil | ding) | |
| | Dr. Janice Ryden | | | nt Bl | vd., | Sui | te 70 | 00, 1 | Baltimore | , Md. | 212 | 224 |
| | SEY U 1 1554 | 32. REGISTRA | R'S SIGNATURE | | | | | | | | | |
| | | | - choware | - | | | | | | | | - 1 |

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| 2 | 88 | |
| at the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending | by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the | |
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BALTIMORE, MARYLAND 21215-0020

ing physician. the burial-transit permit. Pages 1, 2, 3 should TO THE HOSE OF STENDING PHYSICIAN: The law requires that the death certificate be executed with. Thours after death. Page 6 may be retained by the hoss TO THE STANDS After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 5 should be detached be seen with the Charles Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT IT IS A STANDS AND A STANDS AND SAND AND INJURY, or other traumatic event, the medical examiner must be notified at once.

VISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CENI | IFICAL | E OF | DEATH | REG. NO. | | |
|-------------|---|--|---------------------------|---|----------------|--------------------------------------|---|-------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) Te | resa Marie | Henr | y | | | 2. DATE OF DEATH DO | 6 | 3. TIME OF DEATN 94 10:25 a M |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. last birth | | ER 1 YEAR | IF UNDER 24 HRS. | 7 DATE OF BIRTH | | 8. BIRTHPLACE (State or Foreign |
| | 217-72-1601 | | 37 YF | NONTHS | DAYS | HOURS MIN. | 07/31/5 | 7 1 | Michigan |
| _ | 9a. FACILITY NAME (If not institution, give st | | | 9b. Ci | TY, TOWN | OR LOCATION OF DE | | | ITY OF DEATH |
| 9 | 8381 Penn Drive | e | | Pa | asad | ena | | Anne | e Arundel |
| ទួ | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | , | 100 | . CITY, TOWN | 1 00 1 004 | TION | | | 10d. INSIDE CITY |
| DIRECTOR | Maryland Anne | Arunde1 | | | | Pasade | n a | | LIMITS? |
| | 10e. STREET AND NUMBER | TIL GIIGE I | | | 10 | . ZIP CODE | IIa | 10a CITIZ | ZEN OF WHAT COUNTRY? |
| FUNERAL | 8381 Penn Drive | e | | | | 2112 | 2 | | USA |
| 3 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | IN U.S ARMED | 1; | 3. WAS DEC | ENDENT OF HISPAN | IIC ORIGIN? (Specify Yes | _ | 14. RACE - American Indian. |
| | 1 XNever Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 TYES | | | | ecify Cuban, Maxica 2 XIO Specify | n, Puarto Rican, etc.) | | Black, White, atc. Specify: |
| D BY | | | | | | | | | White |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | completed) | 16a. DECEDEI (Give kin | NT'S USUAL d of work don OT use retired | e durina mo | ON ist of working | 16b. KIND OF BUS | SINESS/INDI | USTRY |
| ויב | Elementary/Secondary (0-12) | College (1-4 or 5+) | homer | | , | | homo | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | Homei | nakel | | 18 MOTNED'S NA | NOME (First, Middle, Maiden | Sumamal | |
| | James H. 1 | Henry | | | | | Grace Ani | | mhorman |
| BE | 19a. INFORMANT'S NAME (Type/Print) | 10 | 19b. MAJ | LING ADDRE | SS (Street a | | Route Number, City or Town | | |
| ᄋ | Grace Ann Henry | У | 8383 | l Per | n D | cive Pa | asadena, | MD 2 | 21122 |
| - 1 | 20a. METNOD OF DISPOSITION 1 Burlal 2 Cremetion 3 Ramo | wel from State | h PLACE AND D | ATE OF DISPI | OSITION /A/ | mo of | DATE 200 10 | CATION C | Olly or Town State |
| - 1 | 4 Donetion 5 Other (Specify) | Me | tro Ci | remat | ory | Inc. | 09/07 Bal | ltimo | ore, MD |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENGEE ON AL | A | 2 | 2. NAME AI | VD ADDRESS OF FAC | CILITY | | yland, Inc. |
| | Dawn F. McDo | mald | u | 19 | 9 F | rederic | k Rd. Bal | ltime | ore. MD 21228 |
| | 23. PART I. Enter the diseasee, or c shock, or haert fallure. I | omplications that cause | ed the deeth. | Do not ente | er the mo | de of dying, auci | h ea cardiac or reapi | ratory erre | eat, Approximate |
| | IMMEDIATE CAUSE (Final | Control of the cause of the | eacri imia. | - 0 | - | | ^ | | Interval Between Opset and Death |
| 1 | disease or condition reaulting in death) | OVAR | NAL | C+ | 12 | CINO | omer | | 1 1 year |
| | | DUE TO (OR AS | A CONSEQUENC | CE OF): | | • | | | 7 |
| NO I | Sequentielly liet conditions, | DUE TO (OR AS | A CONSEQUENC | CE OF): | | | | | |
| RTIFICATION | If any, leeding to immediate cause. Enter UNDERLYING | | | | | | | | j |
| | CAUSE (Diseese or Injury that initiated events | DUE TO (OR AS | A CONSEQUENC | E OF): | | | | | |
| CERI | reaulting in death) LAST | i | | | | | | | |
| - 11 | PART II. Other aignificant condition | e contributing to death | but not result | ing in the u | underlyln | g ceuse given in | Part I. 24s. WAS AN | AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| DICAL | | | | _ | | _ | PERFOR | 4 | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| w I | | | | | | | 1 🗆 YES 2 | KNO | OF DEATH? |
| Σ | DID TOBACCO USE CONTR | RIBUTE TO CAUSE O | OF DEATH | YES 🗆 | NO K | UNCERTAIN | , | | 1 - YES 2-NO |
| HYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE OF | | | | | | |
| <u> </u> | 1 YES 2 NO | HOSPITAL: 1 ☐ Inpetient 2 ☐ ER/Out | petient 3 🗆 DC | OTHE | | Residence | 6 Other (Specify) | | |
| E | 27. MANNER OF DEATN | 28a. DATE OF INJURY (Month, Day, Year) | 28b. | TIME OF | 28c. INJ WO | URY AT | 26d. DESCRIBE NOW II | JURY OCC | URED |
| λ | Natural 5 Pending 2 Accident Investigation | | | M | 1 🗆 ' | ES 2 NO | | | |
| 2 | 3 Suicide 6 Could not be determined | 28e. PLACE OF INJUR building, atc. (Spe | Y — At home, te ocify) | rm, street, fe | ctory, offic | • | 281. LOCATION (Street a City or Town, State) | nd Number o | or Rural Route Number, |
| | an organism > 4 | | | | | | | | |
| COMPLET | (Check only | CIAN: To the best of my know | | | | | | | |
| 5 | | - | on and/or investi | getion, in my | opinion, d | eath occured at the | time, date and place, an | due to the | couse(a) and manner ee stated. |
| H H | 294 SHONATURE AND TITLE OF CERTIFIER | (d. He | 1. | 100 |) | 29c. LICENSE NUM | IBER) | | SIGNED (Month, Day, Year) |
| 2 | 30 HAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF THE | We ITEN OF | Time Chinal | | <u> </u> | 177 | P 09 | /06/94 |
| | Russell DeLuca, | | | | Suri | to /10 CT | on Brownia | M | 21.061 |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGN | NATURE | 6 ~ y• | DUL | re 410 G | ren parime | FID . | Z1U01 |
| | SEP 0 7 1994 | John Denden 1 | mobile | | | | | | |
| | - 6 | | | | | | | | |



By 5

DHMH-16 Rev 1/89

| TO THE HOSPITAL OF STRONG BY PASICIAN: The law requires that the death certificate be executed with a hours after death. Page 6 may be retained by the theory TO THE FUNETA OFFICIANS been signed by the aftering physician and completely filled in by the funeral director, page 5 should be detached to the death and Manial Antique and the strong by the funeral director, to have 6 should be detached. | E and | LOTATION OF WITH HE WECCHES, P.O. BOX 68/600 OF A STATE OF STATE O | YSICIAN S certific | The la | w require been signal | s that oned by | the att | th certification of the certif | cate be | succuted and col | within mpletely | nours filled in | after dea | th. Page eral dire | 6 may | BALTIMORE, MARYLANI ther death. Page 6 may be retained by the hose the funeral director, page 5 should be detached | NRY ned by build be | the hog |
|---|--------|--|-----------------------|--------|--------------------------|----------------|---------|--|----------|------------------|--------------------|--------------------|-----------|-----------------------|--------|--|---------------------------|---------|
| we may write it item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | tem 28 | is marke | d, or i | tem 2 | 3 shows | any | njury. | or oth | er traus | natic e | vent, ti | ie med | cai exa | miner | must b | e notif | led at | Once. |

| STATE OF MARY | YLAND / | DEPARTMENT | 0F | HEALTH | AND | MENTAL | HYGIENE |
|---------------|---------|-------------------|----|--------|-----|--------|----------|
| | CE | RTIFICATE | OF | - DEAT | TH | | REG. NO. |

| | FOR STATE REGISTRAR | STATE OF MARYLAN | | TMENT OF I | | MENTAL HYGIEN | | |
|---|---|--|--------------------|--------------------------------------|---------------------|--|----------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF OEATH | | 3. TIME OF OEATH |
| | Cli | nton Wells | Hav. | Jr. | | 09 O | 6 94 | 8:40 a M |
| | 4. SOCIAL SECURITY NUMBER | | rs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRT | THPLACE (State or Foreign |
| | | 1 XM 2 F 82 | YRS. | MONTHS DAYS | OR LOCATION OF D | 02/01/12 | Mar 9c, COUNTY OF | vland |
| OB | 709 Maiden Choi Apt. 113 Freder | ce Lane ick House | | | sville | EATH | Baltin | |
| 딦 | RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY | | 10c. CITY | , TOWN OR LOCA | TION | | | 10d, INSIDE CITY |
| DIRECTOR | Maryland Balti | more | | | Catons | ville | | LIMITS? |
| FUNERAL | 700 Maidon Chaine T. | - A-1 110 D | 1 | | . ZIP CODE | | | WHAT COUNTRY? |
| NEI | 709 Maiden Choice L | | | | 212 | | USA | |
| | 11. MARITAL STATUS 1 Never Merried 2 Merried | 2. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 | NO X | If yes, sp | ecify Cuban, Mexico | NIC ORIGIN? (Specify Year, Puerto Ricen, etc.) | Bia | CE — American Indian, ck, White, etc. |
| ВУ | 3 AWidowed 4 Divorced | IF YES, GIVE WAR OR DATE | S | 1 TYES | 2 NO Specif | у. | Spe | White |
| ED | 15. DECEDENT'S EDUCAT (Specify only highest grade co | | . DECEDENT'S | USUAL OCCUPATE ork done during me | ON | 166, KIND OF BU | SINESS/INDUSTRY | |
| ET | | College (1-4 or 5+) | life. Do NOT us | e retired.) | | | | |
| COMPLETED | | 2 N | lechan | ical E | ngineer | Federa | al Gove | rnment |
| 00 | 17. FATHER'S NAME (First, Middle, Last) | 11- п | | | | ME (First, Middle, Maiden | , | |
| BE | Clinton We | тта нау | | | | Rhoda Bar | | imble |
| 0 | 190. INFORMANT'S NAME (Type/Print) David Michael Ro | 000017 | | | | Route Number, City or Tow | | |
| | | | | Rt. 94 | | n, MD 21 | | |
| | 20e. METNOD 65 DISPOSITION 1 Durial 2 A Cremetton 3 Remove 4 Donetton 5 Other (Specify) | il from State 20b. PL | | her place) | | 09/07 Ba | CATION — City or | |
| | 21. SIGNATURE OF LUMINIAL SERVICE LICES | SHE O LI | O OIC | I 22. NAME A | ND ADDRESS OF FA | CIUTY | гтиюте | , MD |
| | Dawn F. McDon | Mysomala | | Grema | tion So | ciety of | Maryla | nd, Inc. , MD 21228 |
| | 23. PART I. Entar the diseases, or cor | nplications that caused th | e daath. Do n | ot anter tha mo | de of dying, auc | h as cardiac or respi | iratory arreat, | Approximate |
| | shock, or heart failure. List IMMEDIATE CAUSE (Final | | | | | | | Interval Batween Onset and Daath |
| | disease or condition resulting in death) | ACUTE MI | 4 OCA14 | SIAL IN | AHRCTIO! | V | | |
| | | DUE TO (OR AS A CO | | | | | | |
| Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) | | | | | | | | |
| If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | | | | | | | | |
| | | | | | | | | |
| Ē | that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| | d | | | | | | | |
| ÄL | PART II. Other algnificant conditions | contributing to death but | not resulting in | n the underlyin | causa given in | Part I. 24s. WAS AN PERFOR | | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| ă | SEVERE DEPRE | SHOW, CONCE | SUVE IT | CHAN ! | MI CUMB | 1 🗆 YES 2 | . □ NO | COMPLETION OF CAUSE OF DEATH? |
| Σ | AMIAC FIBR | | | | | | | 1 TYES 2 NO |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRIL 25. WAS CASE REFERRED TO MEDICAL | | | | UNCERTAI | N 🗆 📗 | | |
| S | EXAMINER? | IOSPITAL: | | H (Check only one) OTHER: | | 8 Other (Specify) | TRUM - EU | कार्यात मिट्ट |
| HYS | 27. MANNER OF DEATN | 28e. DATE OF INJURY | nt 3 🗆 DOA | | | 8 Other (Specify) 28d. DESCRIBE NOW I | ASSISTO | HVINC |
| = | 1 Natural 5 Pending | (Month, Day, Year) | INJU | JRY WO | RK? | 200. DESCRIBE NOW I | NJOHT OCCURED | |
| ВУ | 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE OF INJURY - | At home, ferm, st | | | 28f. LOCATION (Street e | and Number or Rural | Route Number |
| | 4 Nomicide determined | building, etc. (Specify) | | | | City or Town, State) | | The state of the s |
| COMPLETED | 290. CERTIFIER 1 CERTIFYING PHYSICIA | IN: To the best of my knowledg | e death accur- | d at the three de- | and place and d | to the accordance | | |
| ₩. | | On the basis of exemination en | | | | | | (e) and manner se stated |
| | 290. SIGNATURE AND TITLE OF CERTIFIER | | | | | | | |
| 8 | 000,0 Kg | V | | | 29c, LICENSE NUI | 4 | ≥ 09/0 | D (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO C | COMPLETED CAUSE OF DEATN | (ITEM 27) (Type. | Print) | 40010 | - 4 | . 03/0 | 0/94 |
| | Albin Kuhn, M.D. | | | | ne Cato | nsville, | MD 212 | 228 |
| | SEP 0 7 1994 | 32. REGISTRAR'S SIGNATU | RE | | | | | |
| - 1 | 0-1001 | In water de Von | Apple . | | | | | |

8. BIRTNPLACE (State or Foreign

SC COUNTY OF OFATH

10g. CITIZEN OF WHAT COUNTRY?

3. TIME OF OEATH

IOd. INSIDE CITY 1 YES 2 NO

RACE — American Indian, Black, White, etc.

White

OPOU AM

REG. NO.

16b. KIND OF BUSINESS/INDUSTRY

24a. WAS AN AUTOPSY

PERFORMED?

1 TYES 2 NO

Domestic

2. DATE OF DEATH

Ö0

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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8. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. HOURS 1 M 2 W Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF CEATH DIRECTOR RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 9 2 3 funeral director, page 5 should be detached for use as the burial-transit retained by the hospital or attending physician. 11. MARITAL STATUS WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-1 Never Merried 2 Morris If yes, specify Cubsn, Mexicen, Puerto Rican. etc.) IF YES, GIVE WAR OR DATES Specify: BY 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION

(China kind of work done during most of working COMPLETED 15. OECEDENT'S EDUCATION Elementary/Secondary (0-12) College (1-4 or 5+) once. 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Surname) notified at Louis William Staubitz BE Annie Irene Dell 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. Daniel M. Habicht 9913 Liberty Road Randallstown, MD 21133 death certificate be executed with. Nours after death. Page 6 may be in pe 20a. METHOD OF DISPOSITION

1 XBurlel 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must 4 ☐ Donetion 5 ☐ Other (Specify) Wards Chapel Cemetery 9/8/94 examiner 21. SIGNATURE OF EUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HAIGHT FUNERAL HOME (P.O. Box 195) been signed by the attending physician and completely filled in by the 1 nt. of Health and Mental Hygiene prior to burial, cremation, or removal. Sykesyille, MD 21784 (410)-795-1400 medical 23. PART i. Enter the diseases, or complicatione that wased the death. Do not enter the mode of dying, auch as cerdiac or reapiratory errest, shock, or heart feilure. List only one cause on each line. IMMEDIATE CAUSE (Final the diseese or condition Curren event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF): traumatic Where CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF) if sny, lesding to immediate cause. Enter UNDERLYING 0235 CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART if. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. MEDICAL the DR ATTENDING PHYSICIAN: The law requires that any DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES PHYSICIAN: NO I this certificate has b with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL: 1 YES 2 NO 1 Inpatient 2 - ER/Outpatient 3 DOA 4 Nursing Name 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? marked, 1 Natural 5 Pending 1 YES 2 NO DIRECTOR: After the hours after death v BY 2 Accident Investigation Suicide 28e. PLACE OF INJURY - At ho building, etc. (Specify) 28 Is 8 Could not be COMPLETED 4 Homicide 29e. CERTIFIER 1 (CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated. FUNERAL I HOSPITAL = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: I MEDICAL EXAMINER: On the basic of exa investigation, in my opinion, death occured at the time, date end place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE MHO 2 30. NAMI AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) IMPERIM SEP 7 1994 82. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

> 20c. LOCATION — City or Town, State Randallstown, MD Approximate interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO 28d. DESCRIBE NOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, 29d. DATE SIGNED Month, Day, Year) DHMH-16 Rev 1/89

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DIVISION OF VITAL

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPART | TMENT OF H | REALTH AND | | HYGIENE REG. NO. | | |
|----------|--|---|-------------------------------|---------------------------------|---|-------------------------|-----------------------------------|---------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | 2. DATE OF | DEATH | VEAR | 3. TIME OF DEATH |
| | Clara | | einz | | | Sept | 5. | 1994 | м. |
| | 216 46 1943 | 1 □ M 2 🖔 F | yrs. last birthday) _ 91 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF (Month, L | | Cou | ATHPLACE (State or Foreign Unitry) Maryland |
| - | 9a. FACILITY NAME (If not institution, give stre | et and number) | | 96. CITY, TOWN | OR LOCATION OF D | EATH | 9c. | COUNTY OF | |
| DIRECTOR | 401 . Old Liber | ty Road | | Sykes | sville | | | Carı | coll |
| 3EC | 10e. STATE 10b. COUNTY | | 10c. CITY | , TOWN OR LOCAT | TION | | | | 10d. INSIDE CITY |
| | Md. Carro | 11 | S | ykesvi | 11e | | | | 1 TES STENO |
| JAK | 10e. STREET AND NUMBER | | | 101 | . ZIP CODE | _ | 10g | . CITIZEN O | F WHAT COUNTRY? |
| FUNER | | erty Road | W-10-10-1 | | | 21784 | | | S.A. |
| | 1 Never Married 2 Merried | FORCES? 1 YES IF YES, GIVE WAR OR DAT | | It yea, ap | ENDENT OF HISPAI ecify Cuban, Mexica | en, Puerto Ric | | BI | ACE — Americen Indien, ack, White, atc. |
| ВУ | 3 XWidowed 4 Divorced | IF YES, GIVE WAN ON DAI | £5 | 1 U YES | *X NO Specif | y: | | | oecify: |
| ED | 15. DECEDENT'S EDUCA (Specify only highest grade co | | 16a, DECEDENT'S I | USUAL OCCUPATION done during mo | | 16b. K | IND OF BUSINES | | |
| LET | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use | retired.) | • | | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | Homem | aker | | | Home | | |
| _ | - CHAIR SEATES HOLD CO | | | | 18. MOTHER'S NA | | | me) | |
| BE | Frank R. Myers 190. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street a | IM a.1 | ry Te | | m Zin Codel | |
| 2 | Raymond C. Hei | nz. Jr. | | | Liberty | | | | MD 21784 |
| | 20a. METHOD OF DISPOSITION 1X Burial 2 Cremetion 3 Remov | 20b. P | LACEANDDATEO | FDISPOSITION (Na | arne of | DATE | 20c. LOCATIO | | |
| | 4 Donetion 5 Other (Specify) | Lo Lo | oudon Pa | rk Cemet | tery 9/ | 8/1994 | Balt | imore | e, MD |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEI | NSEE 7/ | 11 | 22. NAME AN | ND ADDRESS OF FA | CILITY | ME (D O | D - | 105) |
| | 1 Duan 6 | 7. Alaid | 1 | Svk | HT FUNER | MD 2 | ME (P.U 1784 (4 | . BOX | 795–1400 |
| | 23. PART i. Enter the diseases, or co | mplicatione that caused t | the deeth. Do no | ot enter the mo | da of dying, suc | h es cerdia | c or reepirator | y srrest, | Approximate |
| | shock, or heert fellure. Li IMMEDIATE CAUSE (Finel | et only one ceuse on esc | in line. | | ~ · · · | | | | Onset and Death |
| | disease or condition resulting in death) | Corest | ne a | teart ; | franchine | | | | |
| | | DUE TO OH AS A C | CONSEQUENCE OF |): | Reguy | 2 4 | • | | |
| O | Sequentielly list conditions, b. | DUE TO (OR AS A C | CONCECUENCE OF | rul | reguy | nout | ~ | | |
| CATIO | if any, leeding to immediate cause. Enter UNDERLYING | DUE TO (OR AS A C | -V- | A-, | 0 0 | | | | |
| 正 | CAUSE (Disesse or Injury thet initiated events | DUE TO (OR AS A C | CONSEQUENCE OF |): | | | | | İ |
| ERT | resulting in deeth) LAST | <i>F</i> | 17N | | | | | | |
| 0 | PART II. Other significent conditione | contributing to death but | t not resulting in | the underlying | T ceuse alves in | Part I a | te. WAS AN AUTO | nev I o | 4b. WERE AUTOPSY FINDINGS |
| CAL | | | PERFORMED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | | |
| MEDIC/ | | | | | | — [¹ | ☐ YES 2 💢N | ° | OF DEATH? |
| 2 | DID TOBACCO USE CONTRI | BUTE TO CAUSE OF | DEATH YES | S \square NO \square | UNCERTAI | N [] | | | 1 NES 2 NO |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL | 26. PLACE OF DEATH (Check only one) | | | | | | | |
| SIC | | HOSPITAL: Inpatient 2 ER/Outpat | | OTHER: 4 - Nursing Hom | e 5 🗆 Rasidence | 8 Other (S | Specify) | | |
| PHY | 27. MANNER OF DEATH | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME | | URY AT | 28d. DESCR | IBE HOW INJURY | OCCURED | |
| BY | 1 Nstural 5 Pending 2 Accident Investigation | | | | rES 2 NO | | | | |
| a | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — building, etc. (Specify | - At home, tarm, st | reet, tactory, office | • | 281. LOCATI City or | ON (Street end Nu Town, State) | imber or Ruri | al Route Number, |
| | 29e. CERTIFIER | | | | | | | | |
| COMPLET | (Check only T CERTIFYING PHYSICIA | AN: To the best of my knowled | | | | | | | |
| Ö | | On the basis of examination a | and/or investigation | , in my opinion, d | eath occured at the | time, data en | | | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | 14- | | | 29c. LICENSE NUI | MBER | 29d. | DATE SIGN | ED (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED GAUGE OF THE | ₩ (ITEM 27) (Type, I | Print) | 0 374 0 | 2 | | 4/6 | 77. |
| | SYED. | S. HOE | MA | tro | 412 | , HA | 2021 | 7 01 | SIVE _ |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNAT | URE | | Lite | JIT. | DI V EMI | 7 | Tom on |
| 1 1 | SEP _ 7 1994 8 | 1 | TO THE | | | | | | |

to .

TO THE HOSPITAL DR ATTS DING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hospital or attending physician.

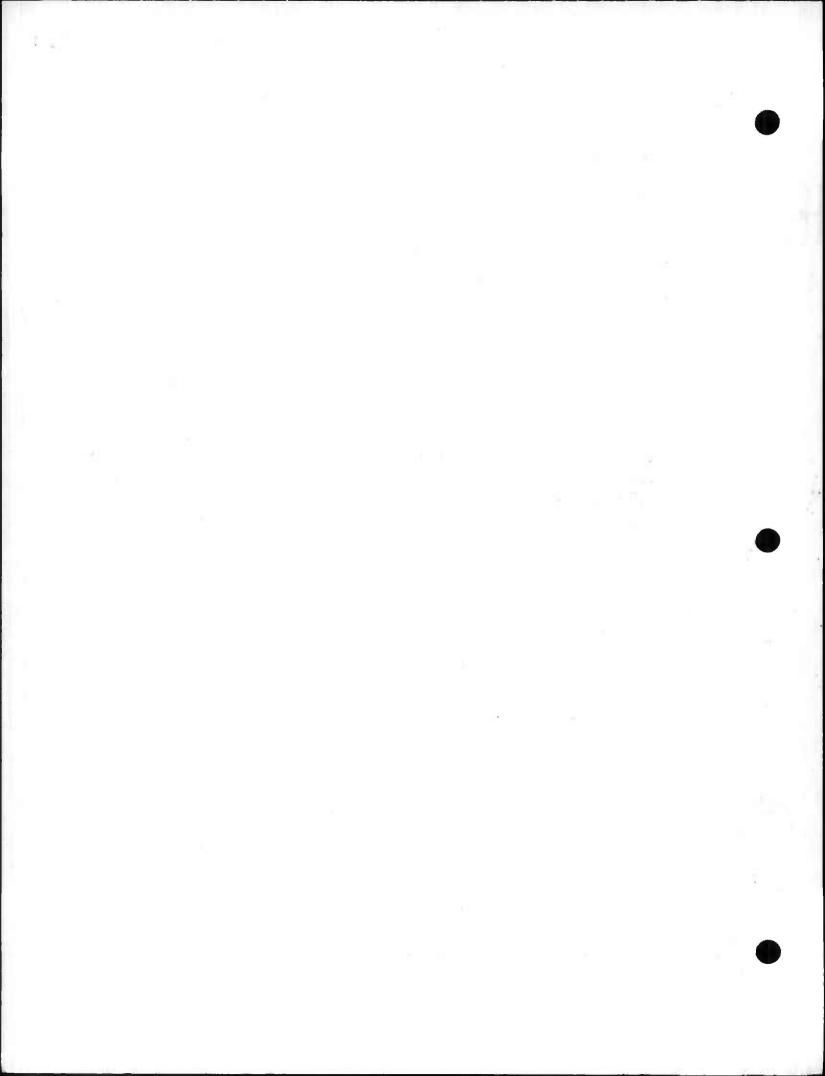
TO THE FUNEX UNEXTALENE THE certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filled within 72 mous after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is, marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | | | | | J "1 | 2000 |
|--------------------|---|--|-------------------------------------|-------------|--|--|----------------------------|---------------------------|----------------|----------------------------|---|
| | 1 - FOR STATE REGISTRAR | STATE OF N | | | | HEALTH AND | | IYGIEN REG. NO | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | / 7 | | | | | 2. DATE OF MONTH | | AY | YEAR | 3. TIME OF OEATH |
| - 1 | 4. SOCIAL SECURITY NUMBER | y 6.0 | ones | 2 | | | 9 | 4 | 9 | 4 | 2005 M |
| 3 | 1 | 5. SEX 1 🕅 M 2 □ F | 6. AGE (In yrs. lesi | YRS. | MONTHS DAYS | | 7. DATE OF (Month, De | y, Year) | | Countr | |
| - | 212-09-8698 9e. FACILITY NAME (If not institution, give s | | 75 | ina. | OF CITY TOWN | OR LOCATION OF D | Nov. | 13, | | Mary | |
| DIRECTOR | St. Agnes Hospi | | | | | imore | EAIR | | 9c. COUP | TIT OF D | EAIH |
| PEC | 10e. STATE 10b. COUNTY | Y | | 10c. CIT | Y, TOWN OR LO | CATION | | | | | 10d. INSIDE CITY LIMITS? |
| | | ltimore | | Ва | ltimore | | | | | | 1 YES 2 XXNO |
| FUNERAL | 100. STREET AND NUMBER 3807 Georgetown | Road | | | | 21227 | | | | | WHAT COUNTRY? STATES |
| BY FUN | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE W | YES 2 N | | It yes, | ECENDENT OF HISPA specify Cuben, Mexico ES 2 A NO Specific | an, Puerto Rica | ipecify Yea n, etc.) | or No- | 14. RACE Black Speci | E — Americen Indian, k, White, etc. |
| | 15. DECEDENT'S EDU | 0.71011 | I Balana | | _ | | | | | | White |
| COMPLETED | (Specify only highest grade | completed) | (Gir | ve kind of | USUAL OCCUPA work done during se retired.) | TION most of working | 16b. KII | OF BU | SINESS/IND | USTRY | |
| PLE | Elementary/Secondery (0-12) | College (1-4 or 5 + | •) | | Attend | ant | Δ1. | tomo | tive | | |
| MO | 17. FATHER'S NAME (First, Middle, Last) | | bta | C1011 | Accend | 16. MOTHER'S NA | | - | | | |
| BE C | John G. Jone | S | | | | Daisy | Taylo | | , | | |
| TO B | 19e. INFORMANT'S NAME (Type/Print) | | 19b | . MAILING | ADDRESS (Street | t end Number or Rural | _ | _ | in, State, Zip | Code) | |
| F | Ida Jones | | 3 | 807 | Georget | own Road | Balti | more | , Mai | rylar | nd 21227 |
| | 20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Rem | oval from State | 20b. PLACE A | ND DATE | OF DISPOSITION | Name of | OATE | 20c. LO | CATION — | City or To | wn, State |
| | 4 Donation 5 Other (Specify) | | Maryl | and | Veteran | s Cemeter | y 9-9 | Cro | wnsv | ille | , Maryland |
| | - FIMIT | An a | | | | ANO ACCRESS OF FA | | | | Lan | Home of sdowne ne, MD21227 |
| | 23. PART i. Enter the diseases, or o | complications tha | t caused the de | ath. Do | not enter the r | node of dying, aud | ch as cardiac | or resp | iratory arr | est, | Approximate |
| | ahock, or heart fellure. IMMEDIATE CAUSE (Fine) | List only one ceu | se on each iina. | | | | | | | | Onset and Death |
| | disease or condition resulting in death) | . 130 | aduc | Sec | rchi | _ | | | | | 10000 |
| | TOTAL AND A | OUE TO | (OR AS A CONSEC | UENCE O | F): | | | | | | |
| NO N | Sequentielly list conditions, | b. OUE TO | OR AS A CONSEC | all MENCE O | L H | - | | | | | 2 day |
| TA. | If any, leading to immediate cause. Enter UNDERLYING | 550 10 | (ON AS A CONSEC | DENCE O | · . | | | | | | · · · · · |
| ERTIFICATION | CAUSE (Disease or Injury that initiated events | c. DUE TO | (OR AS A CONSEC | UENCE O | F): | | | | | | |
| H | reaulting in deeth) LAST | d | | | | | | | | | |
| 0 | PART il. Other algnificant condition | na contributing to | deeth but not re | esulting | In the underly | ing cause given in | Part i 24 | - WEC AN | AUTOPSY | 245 | . WERE AUTOPSY FINDINGS |
| PHYSICIAN: MEDICAL | | | | | | ang occoo given in | | PERFO | RMED? | _ 240. | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| ED | | | | | | | — [ˈ | YES 2 | ZNO | | OF DEATH? |
| Σ. | DID TOBACCO USE | CONTRIBUT | E TO CAU | SE O | F DEATH | YES II N | ò r4 | | | | 1 TES 2 LAO |
| A | 25. WAS CASE REFERRED TO MEDICAL | | - 10 0/10 | 02 0 | | PLACE OF DEATH (C) | | | | | |
| Sic | EXAMINENT 1 DYES 2 NO | HOSPITAL: | ER/Outpatient 3 | □ DOA | OTHER: | ome 5 🗆 Reeldence | 7 - V27 - V | pecify) | | | |
| Ή | 27. MANNER OF OEATH | 26e. OATE OF (Month, D | | 26b. TIA | IE OF 26c. I | NJURY AT WORK? | 28d. DESCR | | NJURY OCC | UREO | |
| BY | 1 Action 5 Pending 2 Accident Investigation | | | | | YES 2 NO | | | | | |
| | 3 Suicide 6 Could not be determined | 26e. PLACE O building, | F INJURY — At hor etc. (Specify) | me, term, | atreet, factory, of | fice | 261. LOCATIO City or To | ON (Street own, State) | end Number | or Rural F | loute Number, |
| COMPLETED | 290. CERTIFIER (Check only one) 1 CERTIFYING PHYSI 2 MEDICAL EXAMINE | | | | | ite and place, end du | | | | | and manner se stated |
| | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | - | | 29c. LICENSE NU | | | | | |
| TO BE | Jan | 1 FIN | NTEN | | | 200000000000000000000000000000000000000 | | | | ×6 | (Month, Day, Year) |
| | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUS | SE OF DEATH (ITEM | 1 27) (Type | Print) | no n | OKGES | FAV | ie) | | |
| l l | | | | 100 | ···· | 100 | 1119 | | | | |

31. DATE FILEO (Month, Day, Year) 7 1994

DHMH-16 Rev 1/89



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| TIMORE, MARYL | |
| BALTIMO | |
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| BOX | |
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| FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | MENTAL HYGIENE REG. NO. |
|--|---|----------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last) | ERCELL B. JOHANNS | 2. DATE OF DEATH MONTH DAY |

| | REGISTRAR | | CE | RITHIC | AIL | F DEATH | | REG. NO |). | | |
|---------------|---|---|--|---------------------------|---------------|-------------------------------|-----------------------------|-------------------------------------|---------------|------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | ERCELL | B. JOH. | ANNS | MS | > | 2. DAT | E OF DEATH | 3 - 9 | EAR X | TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 212-01-7807 | 5. SEX 6. | AGE (In yrs. less | | F UNDER 1 YEA | - | HRS. 7. DAT (Moi | E OF BIRTH oth, Day, Year) 20 | -09 M | Country) | ACE (State or Foreign |
| | 9a. FACILITY NAME (If not institution, give | street and number) | 00 | 9 | b. CITY, TOW | N DR LOCATION | | | 9c. COUNTY | | |
| CTOR | H. WILSON HO | alth Car | e Ce | nterx | G | zith | ers | ourg | Monto | jomei | c y |
| DIREC | 10a, STATE 10b, COUNT | | | | TOWN OR LO | | | 9 | | 10 | Dd. INSIDE CITY |
| | | gomery | | Gait | hersb | | 1000 | | | | YES 2X NO |
| FUNERAL | 10a. STREET AND NUMBER | 3 | | | 124 | 10f. ZIP CODE | | | | N OF WHA | AT COUNTRY? |
| UNE | 403 Russell Ave. | 12. WAS DECEDENT E | | | 13. WAS 0 | 20877 DECENDENT OF H | IISPANIC ORIG | IN? (Specify Ye | | | - American Indian, Vhita, atc. |
| ВУ | 1 Never Married 2 Married 3 Wildowed 4 Divorced | FORCES? 1 IF YES, OIVE WAR | | 10 | | epecify Cuban, N 'ES 2½ NO | Aexican, Puerte Specify: | Rican, etc.) | | Specify: Whit | |
| TED | 15. DECEDENT'S EDI (Specify only highest grad | JCATION completed) | (GI | CEDENT'S US | k done during | ATION most of working | 16 | b. KIND OF BU | SINESS/INDUS | TRY | |
| COMPLET | Elementary/Secondary (0-12) 12 YYS | College (1-4 or 5+) | 53.4 | ро нот use n laims | | ter | | Insura | ance | | |
| OM | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 'S NAME (First | Middle, Malden | | | |
| ш | Frederick | | Buhman | | RE | Bess | ie | | Sc | cott | Marie M |
| TO B | John W. Debelius | III | | | | ond Ave | | | | | 877-982 |
| | 20a. METHOD OF DISPOSITION 1 ☑ Buriel 2 ☐ Cremation /8 ☐ Ren | najyli from Styte | | ND DATE OF I | | | | | OCATION — CIT | | |
| | 4 Donation 8 Ditting (\$5000%) 1 | CENSEE / | Weste: | metory or other rn Cen | 1 | AND ADDRESS | 9- | 7 Ba | altimor | e, M | id. |
| | 5-174 | - Note | | | Ruck | Towson | Funer | al Hom | ne, Inc | | |
| _ | 23. PART I. Enter the disease, or | st/ III | august the de | oth Do not | | York R | | | | | Approximat |
| CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR | AS A CONSECUTION AS A C | OUENCE OF): | etia vin | i | | | | | Onset and (|
| | PART II. Other significant condition | en in Part I. | PERFORMED? AVAI | | | ERE AUTOPSY FINE | | | | | |
| : MEDICAL | | | | | | | | 1 TYES | | 0 | MILABLE PRIOR TO OMPLETION OF CAI F DEATH? |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | | PLACE OF DEAT | 'H (Check only | one) | | | |
| YSI | 1 TES 2 NO | 1 Inpetient 2 EF | - | DOA 4 | - | lome 6 - Raald | | | | | |
| | 27. MANNER OF DEATH 1 Netural 5 Pending | (Month, Day, | | 28b. TIME C | Y | INJURY AT WORK? YES 2 N | | EŞCRIBE HOW | INJURY OCCU | RED | |
| D BY | 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE OF IN building, etc. | | me, farm, atre | | | 28f. LC | | and Number or | Rural Rou | te Number, |
| ETED | 4 Homicide determined | bunding, inc. | (Opecny) | | 180 | | Ci | y or Town, State | | | |
| COMPL | ana) | SICIAN: To the best of my ER: On the bests of exem | | | | | | | | | nd manner as star |
| H | THE SIGNATURE AND TITLE OF CENTIFIE | Comp to | n on | ABUL | HAM | 20e LICENS | 37/6 | | 29d, DATE 5 | BIGNED (M | fonth, Day, Year) |
| 5 | TIBOR E. FREKK | OMD 192 | OF DEATH OTEN | J. Soun | Ky U | MANE | POW | FOR | DRAB | ULI | HARAG- |
| | 31. DATE FILED (Month, Day, Year) SEP () / 1994 | 32. REGISTRAR'S | | JUNE / | 1119 | MY FU | TY | | | | |
| | OLI U 1 1334 | of the Dandes | n- Kurder | | . 30 | | | | | | |

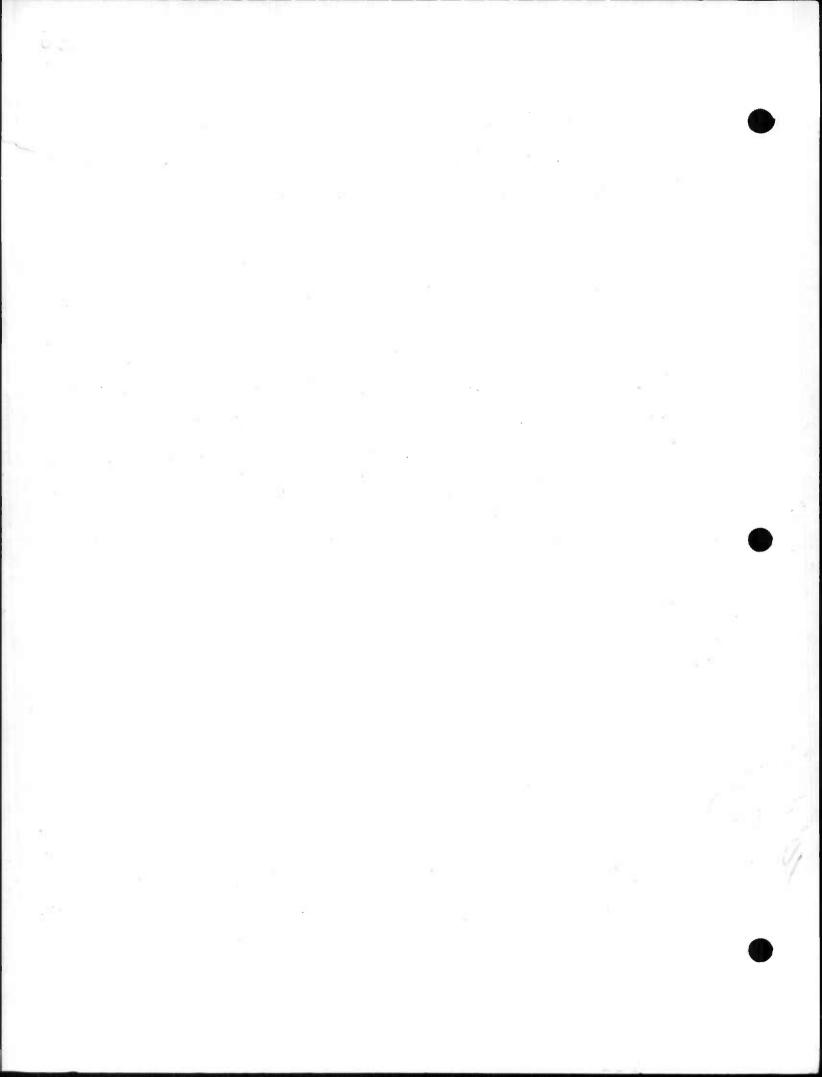
| BALTIMORE, MARYLAND 21215-0020 | after death. Page 6 may be retained by the hospital or attending physician. | Descript with this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should |
|--|---|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760. | FINAL PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician. | TOPE in this certificate has been signed by the attending physician and completely filled in |
| | 1 | B. |

INITION OF THE LAW requires that the death certificate be executed with hours after death. Page 6 may be retained by the host completely filled in by the funeral director, page 5 should be detached the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached with the State Dept. of Health and Mental Hygiene prior to build, cremation, or removal.

TO THE MOSPITAL
TO THE FLIVERA
Be filed within B
IMPORTANTE

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND | MENTAL HYGIENE |
|--|-----------------------|
| CERTIFICATE OF DEATH | REG. NO. |

| | 1 - FOR STATE REGISTRAR | TATE OF MARYLAND / DEI | PARTMENT OF H | | MENTAL HYGIEN | | | | | | |
|----------------------------------|--|--|---|--|---|--|---|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) MILTON A. JAR | KIEWICZ | | | 2. DATE OF DEATH | | 3. TIME OF DEATH 7.05 PM | | | | |
| JR | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 212-12-9526 1 1 M 2 F 844 YRS. MONTHS DAY HOURE MIN. 4. G 1910 MARY/AND 9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS BAYVIEW Baltimore 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore 9c. COUNTY OF DEATH | | | | | | | | | | |
| BE COMPLETED BY FUNERAL DIRECTOR | 10e. STREEF AND NUMBER 10 STOW AVE 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATIO (Specify only highest grade comp.) | NUCE 6713 NAS DECEDENT EVER IN U.S. ARMED PORCES? 1 YES 2 NO F YES, GIVE WAR OR DATES No ened) 16a. DECEDE Give him life. Do N NAR (C) | 13. WAS DEC It yes, sp 1 TYES NT'S USUAL OCCUPATION of of work done during mo 107 use retired.) | ION AC ZIP CODE R 1 2 2 ENDENT OF HISPAN Porting AN 18. MOTHER'S NAI PAULIT | IIC ORIGIN? (Specify Yen, Puarto Rican, etc.) 18b. KINO OF BUTE A ME (First, Middle, Maiden | SINESS/INDUS CO Ne R Surmane) | dowski | | | | |
| OT | 20a, METHOD OF DISPOSITION 1 | The wicz Bos 20b. PLACE AND D competery, crematory A CRE E | ATE OF DISPOSITION (Na y or gifter place) ATE OF DISPOSITION (Na y or gifter place) ATE OF DISPOSITION (Na y or gifter place) 22. NAME AN W. D. A. | Me of MARY DADDRESS OF FAMILY DADDRESS OF FAMILY DOWN SOLVER SOLV | BALTUR DATE 200. CO 9/6 Du CHITY - Char AVE BA | Md. NAAK NACK | 31232 y or Town, State , MARY IAND , F. A. P. A. | | | | |
| CERTIFICATION | 23. PART I. Erter the diseases, or comp shock, or heart fellura. List of immediate cause or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that inlitted events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE DU | DURAL HE CE OF): | | | iratory arrea | t, Approximate Interval Batween Onsat and Death | | | | |
| PHYSICIAN: MEDICAL CE | PART II. Other significant conditions con | ntributing to deeth but not result | ilng in the underlying | cause given in | Part I. 24s, WAS AF PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO | | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | SPITAL: | | ACE OF DEATH (Che | ack only one) | | | | | | |
| YSI | 1 YES 2 X NO 1 X | Inpetiant 2 ER/Outpetiant 3 DC | | | 6 Other (Specify) | | | | | | |
| PH | 27. MANNER OF OEATH 1 Naturel 5 Pending | 26a. OATE OF INJURY (Month, Day, Year) | | RK? | 26d. OESCRIBE HOW | INJURY OCCU | REO | | | | |
| ETED BY | 1 De Naturei 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined determined 26. PLACE OF INJURY — At home, farm, streat, factory, office 25t. LOCATION (Street and Number or Rural Route City or Town, State) | | | | | | | | | | |
| COMPLE | | To the best of my knowledge, death or the bests of examination and/or investi | | | | | | | | | |
| TO BE C | 29b. SIGNATURE OF THE O | | | 29c. LICENSE NUN | 20 | D 9 | SIGNEO (Month, Day, Year) | | | | |
| _ | 30. NAME AND ADDRESS OF PERSON WHO COI C. Duffort Jah 31. OATE FILED (Month, Day, Year) | APLETED CAUSE OF DEATH (ITEM 27) | BAY VIEW | 1494 | Easter | n Av | 21224 e Balto, Md | | | | |
| SEP 0 7 1994 Juin Danison Russel | | | | | | | | | | | |



TO THE HOSPITAL DRATE MATERIAL STATE AND THE Law requires that the death certificate be executed within the nature of the death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours me the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked, or life 2 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

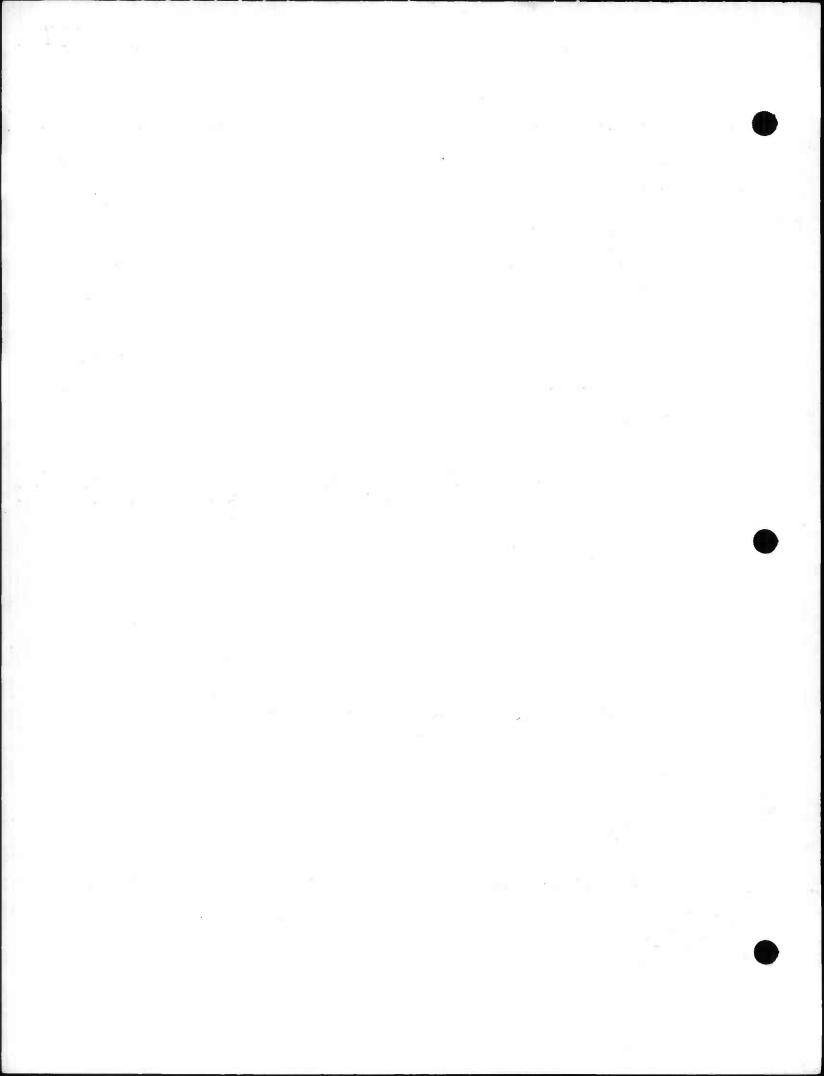
AL RECORDS, P.O. BOX 68760,

| ON OF VI | IN SPYSICIANE TO | After the certificate h | State State |
|----------|------------------|-------------------------|--------------------------|
| | IL OR ATTEN | DIRECTOR | hours arm |
| | TO THE HOSPITAL | TO THE FUNERAL DIREC | he filed within 72 hours |
| | 오 | 균 | 3 |

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENT | TAL HYGIENE |
|---|-------------|
| CERTIFICATE OF DEATH | BEG NO |

| | 1 - FOR STATE OF MARYLAND / DEPARTMENT CERTIFICATE | | MENTAL HYGIEN REG. NO. | E | | | | | |
|------------------|--|--|--|--|---|--|--|--|--|
| | t. DECEDENT'S NAME (First, Middle, Lest) FERNE ESTELLE JOHNSON | | 2. DATE OF DEATH | - Q4 | 3. TIME OF DEATH 10:50P M | | | | |
| | 219-30-3437 1 M 2 X F 44 YRS. | YEAR IF UNDER 24 HRS. DAYS HOURS MIN. | 7. DATE OF BIRTH 02/03/50 | a. BIRT | HPLACE (Stata or Foreign | | | | |
| IOR | 0. 11 1/ 1/ 1/ | TOWN OR LOCATION OF D | EATN | Balti | | | | | |
| FUNERAL DIRECTOR | 10e. STATE 10b. COUNTY 10c. CITY, TOWN OF Maryland | Balti | more | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | | | | |
| VERAL | 3809 Hamilton Avenue | 10f. ZIP CODE 212 | 06 | 10g. CITIZEN OF | WHAT COUNTRY? | | | | |
| BY FUR | 1 To Never Married 2 Merried FORCES? 1 YES 2 TO If | AS DECENDENT OF NISPA yes, specify Cuban, Maxic YES 2 X NO Speci | en, Puerto Rican, atc.) | or No — 14. RAC Blac Spe | E — American Indian, ck, White, atc. city: Black | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Caseworker | CUPATION uring most of working | Fducat | ional (| | | | | |
| BE COM | 17. FATNER'S NAME (First, Middle, Lest) Joseph Edward Johnson | 16. MOTNER'S NA | AME (First, Middle, Malden Ferne Es | Surname) | | | | | |
| 2 | Kristina Estelle Logan 4625 Horiz | on Circle # | | | 1208 | | | | |
| | 206. METNOD OF DISPOSITION 1 Burlel 2 XCremetton 3 Removal from State 4 Donatton 5 Other (Specify) 21. SIGNATURE OF FUNERAL SEBVICE LICENSEE 22. METNOD OF DISPOSITION 206. PLACE AND DATE OF DISPOSITION 207. PLACE AND DATE OF DISPOSITION 208. METNOD OF DISPOSITION 208. METNOD OF DISPOSITION 208. METNOD OF DISPOSITION 208. METNOD OF DISPOSITION 208. PLACE AND DATE OF DATE | Ory, Inc. | 09/02 Ba | CATION — City or 1 | own, State | | | | |
| | Dawn F. McDonald Cre | emation So Frederic | ociety of ck Rd.Bal | timore. | and, Inc. MD 21228 | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the abook, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) | ha moda of dying, suc | ch aa cardlac or respi | ratory arreat, | Approximate interval Between Onset and Death | | | | |
| HIFICATION | DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| AL CEH | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | |
| MEDICA | | PERFOR | MED? | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 28. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | |
| HTOL | t YES 2 NO | ng Home 5 🗆 Residence 26c, INJURY AT | Other (Specify) H | OSPICE | | | | | |
| 2 | Natural S Pending M | WORK? t YES 2 NO | 26f. LOCATION (Street a | and Number or Rural | Route Number, | | | | |
| COMPLETED | 4 Nomicide detarmined building, arc. (specify) 29a. CERTIFIER (Check only one) City or Yown, State) City or Yown, State) | | | | | | | | |
| | 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my op 29b. SIGNATURE AND TITLE OF CERTIFIER CONTROL CONTROL CO | 29c. LICENSE NU | | | (a) and manner as stated. D (Month, Day, Year) | | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL R. FAULKNER, MD, 2300 DULANEY | VALLEY RD. | , TOWSON, | MD 2120 | 4 | | | | |
| | 31. DATE FUED (Moght). Day, Hear) SEP (1994) Janie Sanisan Rudale | | | | DHMH-16 Rev 1/89 | | | | |





ours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

IS JAN: The law requires that the death certificate be executed within

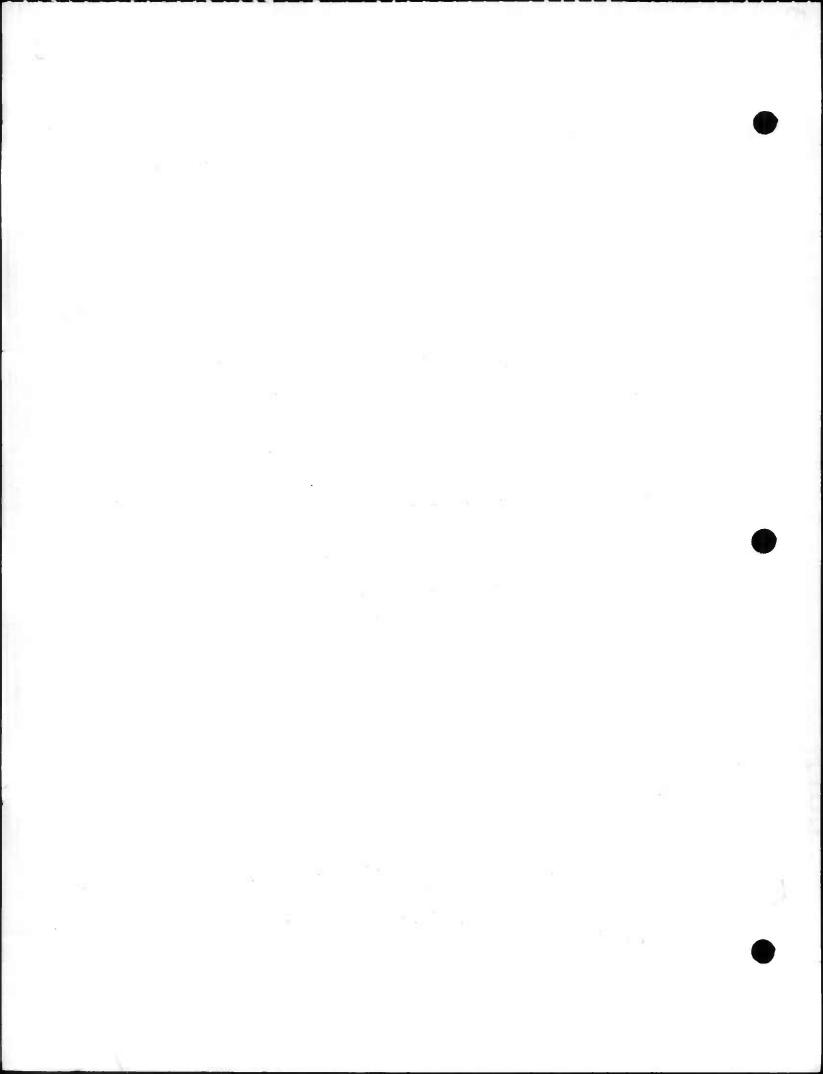
TO THE FUNERAL OR ATTENTO THE FUNERAL DIRECTOR IN De filed within 72 hours en IMPORTANT: If Item 18

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

inflicate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should he State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| THE STIAN ROBERT KLIMT 4. SOCIAL SECURITY NAME (First, Middle, Last) CHRISTIAN ROBERT KLIMT 4. SOCIAL SECURITY NAME (First, Middle, Last) S. SEX 5. SEX 6. SEX | | 1 - FOR STATE REGISTRAR | STATE OF MARY | LAND / DEPARTA CERTIFIC | | | MENTAL HYGIEN | | | | |
|--|---------------|---|-------------------------------|----------------------------|--------------------|--|---------------------------|----------------------|--|--|--|
| CHRISTIAN NOBBERT AND EXPENDENCE OF THE STAT | | 1. DECEDENT'S NAME (First, Middle, L | Lest) | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | | |
| # SOCK SECONTY NAMES S. SEX | | CHRIST | TAN ROBERT | KT.TMT | | | | | 12.10 D.W | | |
| TOWNSON USE OF PROPERTY OF COUNTY TOWNSON TOWNSON OF LOCATION OF | | | | | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | | | |
| SCHITT MARE (If not methods, pile since and analysis) SCHITT MARE | | | | | NTHS DAYS | HOURS MIN. | | Coun | try) | | |
| STREET AND NUMBERS 316 AYTHY Rd. 12. WAS DECIDENT FOR N U.S. ARMED 13. WAS DECIDENT FOR N U.S. ARMED 14. WAS DECIDENT FOR N U.S. ARMED 15. WAS DECIDENT FOR N U.S. ARMED 16. WAS DECIDENT FOR N U.S. ARMED 17. WAS DECIDENT FOR N U.S. ARMED 18. WAS DECIDENT | | 9a. FACILITY NAME (If not institution, g | give street and number) | 98 | CITY, TOWN | OR LOCATION OF DE | | | | | |
| STREET AND NUMBERS 316 AYTHY Rd. 12. WAS DECIDENT FOR N U.S. ARMED 13. WAS DECIDENT FOR N U.S. ARMED 14. WAS DECIDENT FOR N U.S. ARMED 15. WAS DECIDENT FOR N U.S. ARMED 16. WAS DECIDENT FOR N U.S. ARMED 17. WAS DECIDENT FOR N U.S. ARMED 18. WAS DECIDENT | TOR | Greater Baltimo | re Medical Cen | ter | Tow | son | | Balti | more | | |
| STREET AND NUMBERS 316 AYTHY Rd. 12. WAS DECIDENT FOR N U.S. ARMED 13. WAS DECIDENT FOR N U.S. ARMED 14. WAS DECIDENT FOR N U.S. ARMED 15. WAS DECIDENT FOR N U.S. ARMED 16. WAS DECIDENT FOR N U.S. ARMED 17. WAS DECIDENT FOR N U.S. ARMED 18. WAS DECIDENT | Ä. | 10a. STATE 10b. CO | UNTY | 10c. CITY, T | OWN OR LOCA | TION | | _ | | | |
| THE GIVE WAR OR DATE SEMENTS FORCED TO SECURITY | | Md. Baltimore Towson | | | | | | | | | |
| THE GIVE WAR OR DATE SEMENTS FORCED TO SECURITY | AL | 10e. STREET AND NUMBER | | | 101 | . ZIP CODE | | 10g. CITIZEN OF | WHAT COUNTRY? | | |
| The state of the s | E | 916 Army Rd. | | | | 21204 | | II.S | Ά | | |
| THE GIVE WAR OR DATE SEMENTS FORCED TO SECURITY | 5 | | | | 13. WAS DEC | ENDENT OF HISPAN | IIC ORIGIN? (Specify Yes | or No- 14. RAC | E — American Indian, | | |
| THE TENDENTIAN SUPPLIES THE THIRD THE SUPPLIES THE T | | | | | | | | | | | |
| 18. DECERENTS EDUCATION Beamertery/becombing (1911) College (14 or 5 +) Disposal Sequentially (1911) To Anther S NAME (1924 Mode), Analoge (14 or 5 +) Physician 18. MOTHER'S NAME (1924 Mode), Analoge Superment (1911) Seppel Klimt 19. MALINES ADDRESS (Showled of Name of Plant Room, Mode), Analoge Superment (1911) No. MALINES OF DESCRIPTION (1912) 19. MALINES ADDRESS (Showled of Name of Plant Room, Mode), Analoge Superment (1912) 19. MALINES OF DESCRIPTION (1912) 19. MALINES ADDRESS (Showled of Name of Plant Room, Mode), Analoge Superment (1912) 19. MALINES ADDRESS (Showled of Name Room, Name (1924) 19. MALINES OF DESCRIPTION (1914) 19. MALINES ADDRESS (Showled of Name Room, Name (1924) 19. MALINES ADDRESS (Showled of Name Room, Name (1924) 19. MALINES ADDRESS (Showled of Name Room, Name (1924) 19. MALINES ADDRESS (Showled of Name Room, Name (1924) 19. MALINES ADDRESS (Showled of Name Room, Name (1924) 19. MALINES ADDRESS (Showled of Name Room, Name (1924) 19. MALINES ADDRESS (Showled of Name Room, N | | 3 Nidowed 4 Divorced | | | | | | | | | |
| Sequentially list conditions resulting in death) DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN Sequentially list conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH ON NO NO NO NO NO NO NO NO NO NO NO NO | ᇤ | 15. DECEDENT'S (Specify only highest of | EDUCATION grade completed) | (Give kind of work | done during me | ON ast of working | 18b, KIND OF BU | SINESS/INDUSTRY | | | |
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| Sequentially list conditions | | Seppel | Klimt | | | Margar | eta | Hensch | el | | |
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| 200. METHOD OF DISPOSITION 200. INTERCAL STATE 200. LOCATION — City or Town, State 200. LOCATION — Cit | ۴ | Mr. Claudius Kli | imt | 308 Wes | t Wind | Rd. Tow | son, Md. 2 | 1204 | | | |
| ADDRESS OF PLUE OF PLUE AS SERVICE LICENSEE 12. NAME AND ADDRESS OF PLUE AS SERVICE LICENSEE 12. NAME AND ADDRESS OF PLUE AS A COMMEDIAL SERVICE CORP. 10.50 YOR'R Rd. TOWSON, Md. 21.20.4 10.50 | - 1 | | Removal from State | b. PLACE AND DATE OF D | ISPOSITION (No | | | | own, Stata | | |
| 21. RAME AND ADDRESS OF FACILITY RUCK TOWSON FUNERAL SERVICE LICENSEE 22. RAME AND ADDRESS OF FACILITY RUCK TOWSON FUNERAL HOME INC. 1050 YOR Rd. TOWSON, Md. 21204 23. RAME Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cerdiac or respiratory street, intervel Between Onset and Death Report of Conditions, intervel Between Onset and Death Report Tournel and A CONSCIUENCE OF RESULTS OF THE REPORT OF CAUSE (Pinel disease or injury that lindisted events resulting in death) LAST DUE TO IGN As A CONSCIUENCE OF PART II. Other significent conditions, contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN RAME OF DEATH REPORT TO COMPLETION OF CAUSE OF DEATH (Pinex only one) DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH (Pinex only one) DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH (Pinex only one) TO SECURITY OF DEATH REPORT OF CAUSE OF DEATH (Pinex only one) TO SECURITY OF DEATH REPORT OF CAUSE OF DEATH (Pinex only one) TO SECURITY OF DEATH REPORT OF CAUSE OF DEATH (Pinex only one) TO SECURITY OF DEATH REPORT OF CAUSE OF DEATH (Pinex only one) TO SECURITY OF DEATH REPORT OF CAUSE OF DEATH (Pinex only one) TO SECURITY OF DEATH REPORT OF CAUSE OF DEATH (Pinex only one) TO SECURITY OF DEATH REPORT OF CAUSE OF DEATH (Pinex only one) TO SECURITY OF DEATH REPORT OF CAUSE OF DEATH (Pinex only one) TO SECURITY OF DEATH REPORT OF CAUSE OF DEATH (Pinex only one) TO SECURITY OF DEATH REPORT OF CAUSE OF DEATH (Pinex only one) TO SECURITY OF DEATH REPORT OF CAUSE OF DEATH (Pinex only one) TO SECURITY OF DEATH REPORT OF CAUSE OF DEATH (Pinex only one) TO SECURITY OF DEATH REPORT OF CAUSE OF DEATH (Pinex only one) TO SECURITY OF DEATH REPORT OF CAUSE OF DEATH (Pinex only one) TO SECURITY OF DEATH REPORT OF CAUSE OF DEATH (Pinex only one) TO SECURITY OF DEATH REPORT OF CAUSE OF DEATH (Pinex only one) TO SECURITY OF DEATH REPORT OF CAUSE OF DEATH (Pinex only one) TO SECURITY O | | | | illtop Ser | vice C | orp. 9/ | 2/94 To | wson. Md | | | |
| 22 PART 1 Enfer the diseases, or complications that caused the death Do not enter the mode of dying, such as cerdiac or respiratory streat, shock, or heart fellure. List only/one cause on each line. IMMEDIATE CAUSE (Finel diseases or condition resulting in death) Due To giff as a Consequence of such as a conditions, list of the such as a condition of such as a co | | 21. BIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | |
| Approximate neck, or heart fellure. Liet only/one cause on each line. Approximate neck, or heart fellure. Liet only/one cause on each line. Approximate neck, or heart fellure. Liet only/one cause on each line. Approximate neck, or heart fellure. Liet only/one cause on each line. Approximate neck, or heart fellure. Liet only/one cause on each line. Approximate neck, or heart fellure. Liet only/one cause on each line. Approximate neck, or heart fellure. Liet only/one cause on each line. Approximate neck, or heart fellure. Liet only/one cause on each line. Approximate neck, or heart fellure. Liet only/one cause on each line. Approximate neck, or heart fellure. Liet only/one cause on each line. Approximate neck, or heart fellure. Liet only/one cause on each line. Approximate neck, or heart fellure. Liet only/one neck, or heart fellure. Liet only one neck, or heart fellure. Liet only one neck, or heart fellure. Liet one neck fellure fellure. Liet one | | | | | | | | | | | |
| Intervel Between Onset reliure. Let only one cause on each line. IMMEDIATE CAUSE (Finel idisease or condition resulting in death) Sequentially list conditions. If any, leading to immediate of the conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not include given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying caus | \dashv | 20 Barry Finler the diseases | or complication that | 14.1. | 1050 | York Rd. | Towson, M | d. 21204 | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury Due TO IOM AS A CONSEQUENCE OF: | | iMMEDIATE CAUSE (Finel disease or condition | are. Liet only/one cause on | each line. | | 0.59 | ove. | natory streat, | Intervel Between | | |
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| 25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 | MEDIC | PERFORMED? 1 YES 2 NO DF D | | | | | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? | | |
| 2 Accident investigation 2 Accident 2 Ac | ÿ∥ | | | OF DEATH YES | □ NO □ | UNCERTAIN | 1 🗆 | | | | |
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| 2 Accident investigation 2 Accident 2 Ac | E | | (Month, Day, Year) | INJURY | | | 28d. DESCRIBE HOW I | NJURY OCCURED | Beneddianos | | |
| 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and other cause(s) and manner as stated. 29b. Signature and other cause(s) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month) Dec. Visit of Cause of Open April 10 Cause of | | | 8 24.0 | PUA | | | Overd | 050 00 | DOITES | | |
| 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINES: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. LICENSE NUMBER 29d. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) 31. DATE FILED (Monthy Day, Year) 31. DATE FILED (Monthy Day, Year) | | 3 Suicide 6 Could not | building, atc. /Soe | Y — At home, farm, stree | t, factory, office | | 281. LOCATION (Street | and Number of Rund | Papurar Numbers | | |
| 296. SIGNATURE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) 31. DATE FILED (Morith Dec.) March. 23. BECISTRAP'S SIGNATURE | 4 | 4 Homicide determine | 4 | /- | | | Only Or IOWII, State) | | | | |
| 296. SIGNATURE AND JITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNEO (MORRIT, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) 31. DATE FILED (MORRIT Day, Year) 31. DATE FILED (MORRIT Day, Year) 31. DATE FILED (MORRIT Day, Year) | MPLE | (Check only CERTIFYING PI | | viedge, death occurred at | | | | | | | |
| 30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) 31, DATE FILED (Morphy Dec Work) 31, DATE FILED (Morphy Dec Work) 31, DATE FILED (Morphy Dec Work) 32, DECISTRAP'S SIGNATURE | 3 | | | androi investigation, ii | my opinion, o | | | d due to the cause(| s) and manner as stated. | | |
| 30, MANÉ AND ADORESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) 30, MANÉ AND ADORESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) 31, DATE FILED (Monthly Dec.) March 31, DATE FILED (Monthly Dec.) March 31, DATE FILED (Monthly Dec.) March 32, DECISTRAP'S SIGNATURE | | 290. SIGNATURE AND TITLE OF CERT | IFIER COL | 7 001 | 7 | 290 LICENSE NUM | BER | 29d, DATE SIGNED | (Month, Day, Year) | | |
| 31. DATE FILED (MODIN DONNEL) A 23 BECKSTAR'S SIGNATURE | | MI Wills | TURION | wellthe | 6 | 1073 | 83 | 7-1- | 94 | | |
| 31. DATE FILED (MORNY) Days March | | JOY OF PERSON | WHO COMPLETED CAUSE OF OF | EATH (ITEM 27) (Type, Prin | X08 | x62 rho | Marie | 30/6 | 1044/11 DI | | |
| | | 31. DATE ELED (MONTO 1994 | 32. REGISTRAR'S SIGN | ATURE | | The state of the s | 7400 | CITYON. | I I I I Ke | | |



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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MONTH 9 8:00 A. Catherine Angela Krauch 94 6 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign use as the burlal-transit permit. Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR View rope RESIDENCE C EDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY YES 2 NO Lozope FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF 2/2 13 BONVIEW retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 1F YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC OBIGIN? (Specify Yee or No-ff yes, specify Cuben, Mentain, Puerto Rican, stc.) BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Merried BY 1 TYES 2 AND Specify: 3 -Widowed 4 Divorced LIYE COMPLETED 18e. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY Ive kind o Do NOT for (0-12) College (1-4 or 5+) 87 be detached Nean 17. FATHER'S NAME (First, Middle, Last) Ħ BE Should notified 190. INFORMANT'S NAME (Type/Print) 2 376 BONVIEWAUR funeral director, page 5 executed with nours after death. Page 6 may be must be 20a, METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION DATE 3 🗆 ARYLAND 4 Donation 5 Other (Specify) ene examiner RAL BERVICE LICENSEE JOSEPH N Zannino Jr. Funeral Home 263 Conkling St. Balto, filled in by the or removal medical na thet ceused tha death. Do not enter the mode of dying, such ea cardiec or respiratory erreat, Approximete Intervai Between shock, or heart one cause on each line IMMEDIATE CAUSE (Final Onset and Death cremation. other traumatic event, the diseese or condition Xa attending physician and completely 10. resulting in deeth DUE TO (OR AS A CONSEQUENCE OF): burial, CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Drior to If any, leading to immediate ceuse. Enter UNDERLYING death certificate be CAUSE (Disease or injury Mental Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 0 Injury, n signed by the a PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert i. the 24a. WAS AN AUTOPSY PERFORMED? WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL requires that 23 shows any COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 TES 2 NO of certificate has been PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO P SW Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OR ATTENDING PHYSICIAN: The Item State EXAMINER? 1 YES 2 NO OTHER: 1 Inpatient 2 I ER/Outpatient 3 I DOA 0 the th 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED marked, With this Natural Pending Investigation BY 1 YES 2 NO death DIRECTOR: After 2 Accident 26e. PLACE OF INJURY — At home, ferm, street, fectory, office building, stc. (Specify) 28 is r 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be hours after 4 Homicide Item 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge. (Check only one) 2 MEDICAL EXAMINER: On the 296. SIGNATURE AND TITLE OF CUP 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 0 COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 560 Loch HALN 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

Davide

1.5 2010

| BALTIMORE, MARYLAND 21215-0020 | SISIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician. | certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the Star fleet of Health and Mental Hyniene prior to burial cremation or remnal | medical examiner must be notified at once. |
|--|--|--|---|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760. | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with | TO THE PLACEAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director of the formula of the funeral file of the formula the formula formu | INPORTANT I I marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM | | | MENTAL HYGIEN | _ | | |
|------------|--|--|---|--------------------|--------------------|---|------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | |
| | MENDEL | L P. KOVAR | | | | -173 | AY YE | 4 7:50 PM | |
| - 33 | 4. SOCIAL SECURITY NUMBER | | | | | | | BIRTHPLACE (State or Foreign | |
| 0 | 215-12-9743 | %□ M 2 □ F 7 | 8 YRS. MON | ITHS DAYS | HOURS MIN. | (Month, Day, Year) 10-13-1 | 0 | Pennsylvania | |
| | 9a. FACILITY NAME (If not institution, give | | | CITY, TOWN O | R LOCATION OF DI | | 9c. COUNTY | | |
| DIRECTOR | John Hopkins BAyview Med. Ctr. BAltimore | | | | | | | | |
| Ĕ | 10e. STATE 10b. COUN | TY | 10c. CITY, TO | WN OR LOCAT | ON | ··· | | 10d, INSIDE CITY | |
| | Md. Bal | Ltimore | Dur | ndalk | | | | t ☐ YES 2 X NO | |
| الج | 10e. STREET AND NUMBER | | | 101. | ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? | |
| FUNERAL | 6 Township Ro | oad | | | 21222 | | U.S | . A . | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | | | | NIC ORIGIN? (Specify Ya | or No- 14. | RACE — American Indian. | |
| BYF | 1 Never Married 27 Married 3 Widowed 4 Divorced | FORCES? 1 YES | 2 NO | If yea, ape | | n, Puarto Rican, etc.) | | Black, White, etc. Specify: | |
| | | | W.II Arm | , | 71 | | | WHite | |
| ED | t5. DECEDENT'S ED (Specify only highest grad | UCATION de completed) | 16a. DECEDENT'S USO (Give kind of work | done during mos | N it of working | 16b. KIND OF BU | SINESS/INDUST | RY | |
| | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use ret | ired.) | | | | 1 | |
| COMPLET | 12 | +4 | Roller | | | | 1 Cor | ρ. | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Malden | | | |
| B | Isador Kovar 19a. INFORMANT'S NAME (Type/Print) | • | | | | esa Mar | | | |
| 2 | Marion Kovar | i. | | | | Route Number, City or Tow | | | |
| - 1 | 20a. METHOD OF DISPOSITION | | b. PLACE AND DATE OF DI | | | ndalk, M | CATION — City | | |
| | 1 Burial 2X Cremation 3 Res | movel from State CO | metery, crematory or other p | placel | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE L | ICENSEE | reenMount | 22 NAME AN | D ADDRESS OF EA | CHITY | | o.,Md. | |
| | D. O O. C. | Robert | Lewis | Brad1 | ev-Ash | ton Fune | ral Ho | 21222 ome, Inc. | |
| | hours () | eury 10 | 0950 | 12134 | W I C W | Spring | RU RA | I TO MO | |
| | 23. PART i. Enter the diseeses, or shock, or heart failure | r complicatione that ceuse . List only one cause on a | ed the desth. Do not e | enter the mod | de of dyling, auc | h as cerdiac or reep | iratory arrest, | Approximete Interval Between | |
| | IMMEDIATE CAUSE (Final | 0. | | | | | | Oneat and Death | |
| | disease or condition resulting in death) | · FUL | MONARY | Em | BOLLE | 5M | | ZHRS. | |
| | | DUE TO TOR AS | A CONSEQUENCE OF): | | | | | 2YRS | |
| 5 | Sequentially list conditions, | | A CONSEQUENCE OF: | HE | AKT F | ATLURE | | ZYKS | |
| HIFICATION | If any, leading to immediate cause. Enter UNDERLYING | DOE TO (ON AS | A CONSEQUENCE OF): | | | | | | |
| 음 | CAUSE (Disease or injury that initiated events | c. DUE TO (OR AS | A CONSEQUENCE OF): | | | | | | |
| | resulting in death) LAST | 4 | | | | | | | |
| 5 | | u. | | | | | | | |
| Ä. | PART II. Other significant condition | ina contributing to death i | but not resulting in th | ne underlying | cause given in | Part 1. 24a. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | |
| MEDIC | | | | | | 1 YES 2 | NO | COMPLETION OF CAUSE DF DEATH? | |
| 빌 | | | | | | | | 1 TYES 2 NO | |
| ž | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | l or | 26, PL | ACE OF DEATH (Ch | eck only one) | | | |
| 2 | 1 YES 2 NO | 1 Inputient 2 ER/Out | | | 5 🗆 Residence | 6 Other (Specify) | | | |
| | 27. MANNER OF DEATH 1 Natural 5 Pending | 28a. DATE DF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | WO | RK? | 28d. DESCRIBE HOW I | NJURY OCCURE | D | |
| à l | 2 Accident Investigation | | | | ES 2 NO | | | | |
| N | 3 Suicide 8 Could not be 4 Homicide datarmined | building, atc. (Spe | Y — At home, farm, street ecrly) | t, factory, offica | | 281. LOCATION (Street City or Town, State) | and Number or R | tural Route Number, | |
| М | e. CERTIFIER | | | | | | | | |
| € | (Check only | SICIAN: To the best of my know | | | | | | | |
| H | 2 MEDICAL EXAMIN | NER: On the beals of exemination | on and/or investigation, in | my opinion, de | ath occured at the | time, data and placa, ar | d dua to the car | use(s) and manner as stated, | |
| 200 | 296. SIGNATURE AND TITLE OF CERTIFI | and a recommendation of the same | _ | | 29c. LICENSE NUI | | 29d. DATE SIG | GNED (Month, Day, Year) | |
| 5 | yman | | 7 | | MOZ | 44 | 8 | 13//94 | |
| | 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CAUSE OF DE | EATH (ITEM 27) (Type, Prin | () | | | 34/2 | D, MD Z1287 | |
| | JOHN MC | PHERSON, MD | , 600 N. h | JOLFE | 9,10 | WER 110, | H77C/C | 21201 | |
| | SEP 0 7 1994 | 32. REGISTRAR'S SIN | NATURE | | | | | | |
| | SEF UT 1331 | (/ | | | | | | 1 | |

light .

| | 1 - STATE REGISTRAR | | AND / DEPARTI CERTIFIC | ATE OF | | REG. NO. | |
|---|--|---|---|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, L | TE OF DEATH DAY 9 - 05 - 9 | YEAR 3. TIME OF DEATH 5:35p | | | | |
| 모 | 4. SOCIAL SECURITY NUMBER 162-20-6787 | | F UNDER 24 HRS. 7. DAT (Mc) | re of BIRTH onth, Day, Year) -21-26 | e. BIRTHPLACE (State or Foreign Country) Pennsylvania | | |
| ages 1, 2, 3 should | 99. FACILITY NAME (If not Institution, of Meyer Median Residence/OF December) | ical Center | / | 711 | OFC . | 9c. COUN | TY OF DEATH |
| AL DIRECT | 10e. STATE 10b. CO | | | TOWN OR LOCATIO | N | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO |
| is I C | 10% STREET AND NUMBER 247 Sandhill R | oad | | | 1221 | | ited States |
| BY FUNI | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES | 2 X NO | If yes, speci | IDENT OF HISPANIC ORK Ity Cuben, Mexicen, Puerl X NO Specify: | GIN? (Specify Yee or No— to Rican, atc.) | 14. RACE — American Indian, Black, White, etc. Specify: White |
| once. COMPLETED | 15. DECEDENT'S (Specify only highest of Elementary/Secondary (0-12) | | 16a. DECEDENT'S US (Give kind of wor life. Do NOT use I | k done during most | | Banking | JSTRY |
| at once. | 17. FATHER'S NAME (First, Middle, Last Mauro Jose | , | OTOTA | | | t, Middle, Meiden Surneme) ilamin Chase | |
| TO BE | 190. INFORMANT'S NAME (Typo/Print) Mr. John E. Ko | | | Sandhill | Number or Rural Route No | Imber, City or Town, State, Zip Itimore, Md. | Code) |
| er must be | 20e. METHOD OF DISPOSITION 1 | Entombment P | PLACE AND DATE OF DELETING THE PARKWOOD | cemetery | 9/9/9 | ATE 20c. LOCATION — C | ore, Marylane |
| ilcal examiner must be | 21. SIGNATURE OF FUNERAL SERVICE Macht | · Zauryn | | Leona 5305 | and J. Ruck Harford Ro | ad Baltimo | ore, 21214 |
| Hygiene prior to burial, cremation, or re or other traumatic event, the med ERTIFICATION | 23. PART i. Enter the diseases, shock, or heert feit immediate CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | a. Metast DUE TO (OR AS A DUE TO (OR AS A C. | ach line. | neast (| Carcinom Jar Accia | | Approximate interval Both Onset and E Pweek |
| 울림그 | | | | | | | |
| ws any | PART II. Other significent cond Hypothyroid | | ut not resulting in | the underlying | cause given in Part i. | 24a. WAS AN AUTOPSY PERFORMEO? . 1 YES 2 NO | AVAILABLE PRIOR TO COMPLETION OF CAL OF DEATH? |
| the State Dept. of Health ar or Item 23 shows any HYSICIAN: MEDIC | | HOSPITAL: 1 Minpetient 2 - ER/Outp | petient 3 □ DOA | 28. PLA | CE OF DEATH (Check only | PERFORMEO? . 1 VES 2 NO one) | 1 TYES 2 NO |
| ter death with the State Dept. of Health at 8 is marked, or item 23 shows any ED BY PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAEXAMINER? 1 | AL HOSPITAL: 1 Minpetient 2 ER/Outp 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Spec | Detient 3 DOA 4 | 28. PLAN DTHER: Nursing Home Very Nursing Work Y M 1 YE | CE OF DEATH (Check only 5 | PERFORMEO? . 1 YES 2 NO | AMAILABLE PRIOR TO COMPLETION DF CAU OF DEATH? 1 YES 2 NO |
| 72 hours after death with the State Dept. of Health at Il Item 28 is marked, or Item 23 shows any MPLETED BY PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: 1 Paper 2 = ER/Outp 28e. DATE OF INJURY (Month, Dey, Year) 28e. PLACE OF INJURY building, etc. (Spec | 28b. TIME (INJUR | 28. PLAN DTHER: Nursing Home Nursing Home 28c. INJUF WORN 1 YE pet, factory, office | CE OF DEATH (Check only 5 Realdence 8 Of 7 AT 28d. E 8 2 NO 28t. L Cond place, and due to the | PERFORMEO? 1 YES 2 NO one) ther (Specify) DESCRIBE HOW INJURY OCC OCATION (Street and Number of Town, State) | AMAILABLE PRIOR TO COMPLETION DF CAU OF DEATH? 1 YES 2 NO URED Or Rural Route Number, |
| The death with the State Dept. of Health at 18 is marked, or Item 23 shows any ED BY PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | AL HOSPITAL: 1 Minpetient 2 ER/Outp 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Special of the second of the | 28b. TIME (INJUR | 28. PLAM DTHER: Nursing Home DF VENOR WORN M 1 VENOR VORING St the time, date et in my opinion, dea | CE OF DEATH (Check only 5 Realdence 8 Of 7 AT 28d. E 8 2 NO 28t. L Cond place, and due to the | PERFORMEO? 1 YES 2 NO one) ther (Specify) DESCRIBE HOW INJURY OCC DCATION (Street and Number of Yown, State) cause(a) and manner as state atte end place, end due to the | AWAILABLE PRIOR TO COMPLETION DF CAU OF DEATH? 1 YES 2 NO URED Or Rural Route Number, |

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Switz and State of the

LANS. The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burne. State Dept. of Health and Mental Hygene prior to burial, cremation, or removal.

Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| rcem | IUD, | g-/13, | 9-/-94, | her. | ГоПор | ur. | |
|------|------|--------|---------|------|-------|-----|--|
| COP | | | | | | | |

| | | FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | |
|---|---------------|--|---|-----------------|--|---------------|-----------------------|---------------------------------------|----------------|--------------|--|
| | | 1. DECEDENT'S NAME (First, Middle, Let L, YNDA | J. | KI | EFFER | | | 2. DATE OF DEATH MONTH SEPTEMBE | DAY | YEAR QQ/I | 3. TIME OF DEATH 3:38 a. M |
| | | 4. SOCIAL SECURITY NUMBER | | E (In yrs. last | birthday) IF L | NDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year |) | | IPLACE (State or Foreign |
| pino | | 218-56-0308 9e. FACILITY NAME (If not institution, given | 1 M 2 XF | 43 | YRS. 9b. | CITY, TOWN | OR LOCATION OF DE | Sept.8, | | Ma1 | ryland EATH |
| 2, 3 should | CTOR | | PKINS HOSPITA | AL | | | ORE CITY | | | | |
| E | RECI | | NTY Prince Georg | | 10c. CITY, TO | MN OR LOCA | TION | | | | tod. INSIDE CITY |
| TV | ē | Maryland Pri | nce RGeorges | | I | aurel | | | | | 1 TES 2 X NO |
| (X | K | 12411 Radnor | Lane | | | 10 | 4. ZIP CODE 20708 | 8 | | J.S.A | VHAT COUNTRY? |
| | S | 11. MARITAL STATUS 1 Never Merried 2 Merried | 12. WAS DECEDENT EVER FORCES? 1 YE | R IN U.S. ARI | MED O | | CENDENT OF HISPAN | IIC ORIGIN? (Specify | Yea or No- | 14. RACE | — American Indien, |
| ding phys | B | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR | DATES | | 1 TYES | S 2 X NO Specify | r: | | Speci | White |
| or attend | ETED | 15. OECEDENT'S E (Specify only highest gri | ade completed) | (Gh | CEDENT'S USUA ve kind of work of Do NOT use reti | lone durina m | | 16b. KIND OF | BUSINESS/INC | USTRY | |
| the hospital o detached for once. | TO BE COMPL | Elementary/Secondary (0-12) N/A | College (1-4 or 5+) N/A | | | / | chasing | Bell | Atlar | ntic | |
| by the hos be detach at once. | | 17. FATHER'S NAME (First, Middle, Last) | ahma an | | | | 27.0 | ME (First, Middle, Mei | den Surname) | | |
| s should by | | George Henry J. 190. INFORMANT'S NAME (Type/Print) | onnson | 196 | MAILING ADD | RESS (Street | Anne (| | Town State 7in | Cortel | |
| e retained e 5 should notified | | James Glenn Kef | fer, Jr. (hus | | | | r Lane, 1 | | | | |
| e 6 may be ector, page must be | | 20a METHOD OF OISPOSITION 1 A Burlet 2 Cremetion 3 R | emoval from State | Ob. PLACE A | ND DATE OF DIS | POSITION (N | - | DATE 20c | LOCATION - | | |
| Page 6 I direct | | 4 ☐ Donation 5 ☐ Other (Specify) | | Garde | ns of I | | ND ADDRESS OF FA | | altimo: | re, l | Maryland |
| nours after death. Page 6 may be retained by the hospital or attending d in by the funeral director, page 5 should be detached for use as the or removal. medical examiner must be notified at once. | | 12 | fell. | | | Schi | munek Fur Belair B | neral Hom | | | 21236 |
| hours after ad in by the or remova medical | | 23. PART Enter the diseasea, of ahock, or heart fallur | or complications that cause on | sed the dea | ath. Do not e | nter tha me | ode of dying, auc | h ae cardiac or re | epiratory an | ee1, | Approximate interval Between |
| y fille then, | | IMMEDIATE CAUSE (Final disease or condition | Secris | t | Unter | 0000 | 127 mlar | | | | Onset and Death |
| ompletel crema event, | | reaulting in death) | DUE TO (DR AS | S A CONSEC | UENCE OF): | 1 | E HOW. | 7 | | | - I day s |
| be executed sician and conrior to burial, traumatic en | NO. | Sequentially list conditions, if any, leading to immediate | b. Cardrac Due TO (OR AS DUE TO (OR AS DUE TO (OA AS | dus Conseo | UENCE OF): | ma | lignount | arrhy+1 | mics | | 7 days |
| hysician prior | ICAT | cause. Enter UNDERLYING CAUSE (Disease or Injury | . Myelodys | plastic | - Syndr | one_ | 1 Acute M | geloperou | 5 Leut | om | 2 years |
| the death certificate be the attending physician of Mental Hygiene prior Injury, or other trau | CERTIFICATION | that initiated eventa resulting in death) LAST | DUE TO (OR A) | S A CONSEC | UENCE OF): | | | , , | | | |
| the death y the atter d Mental Injury, o | | PART ii. Other significant condit | ons contributing to death | but not re | eaulting in th | a underlyin | a cause given in | Part i. 24s WAS | AN AUTOPSY | 24h | . WERE AUTOPSY FINDINGS |
| | EDICAL | 0 | Aral Westolog | 1 | | | 1 | PER | FORMED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| The law requires that the has been signed by are Dept. of Health and and 23 shows any | Σ | DID TODA CCO LICE | CONTRIBUTE TO | 0.110 | | | | _ | | | 1 TYES 2 THO |
| has be Dept. | SICIAN: | DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL | CONTRIBUTE TO | CAUS | E OF DE | | LACE OF DEATH (Ch | | | | |
| MN: The ficate h State I | rsic | 1 TYES 2 NO | HOSPITAL: | utpatient 3 | | HER: | ne 5 🗆 Residence | | | | |
| M | РНҮ | 27. MANNER OF DEATH 1 Netural 5 Pending | 28e. DATE OF INJUR (Month, Day, Year | | 28b. TIME OF INJURY | W | JURY AT ORK? | 28d. DESCRIBE HO | W INJURY OC | CURED | |
| | D BY | 2 Accident Investigation 3 Suicide 8 Could not it | 28e. PLACE OF INJUI | IRY — Al hor | me, term, atreet | | YES 2 NO | 281. LOCATION (Str | | or Rural F | 3oute Number, |
| HET IN | ETE | 4 Homicide determined | | pocity) | | | | City or Town, S | 1919) | | |
| THE HOSPITAL OR I THE FUNERAL DIHER filed within 72 hours PORTANT: If Item | COMPL | one) | YSICIAN: To the bast of my kn INER: On the basia of examina | | | | | | | | i) end manner as stated. |
| TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: II | | 29b. SIGNATURE AND TITLE OF CERTIF | | Ser | non Cli | لنيس | 29c. LICENSE NUI | | | | (Month, Day, Year) |
| H C C H C C C C C C C C C C C C C C C C | O BE | Jam 1. i | tersen M | 4.0 | ellew in | _ | | |) 0 | 14 | 194 |
| | - | 30. NAME AND ADDRESS OF AFRSON | WHO COMPLETED CAUSE OF | - 1 | | 50 | lus Hopker | is oncolo | JI Ca | iten | MD 21787 |
| | | 31. DATE FILED (Month Day Your) 10 | QA 32. REGISTRAR'S SI | SNATURE | Condella | - , 60 | 00 N. WO | ite St, | Daltu | ione i | MU 11 487 |
| | | OFLA 12 | MET O | * | AMERICA CO | | | | | | |

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DIVISION OF VITAL RECORDS, P.O. E

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an order of the death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

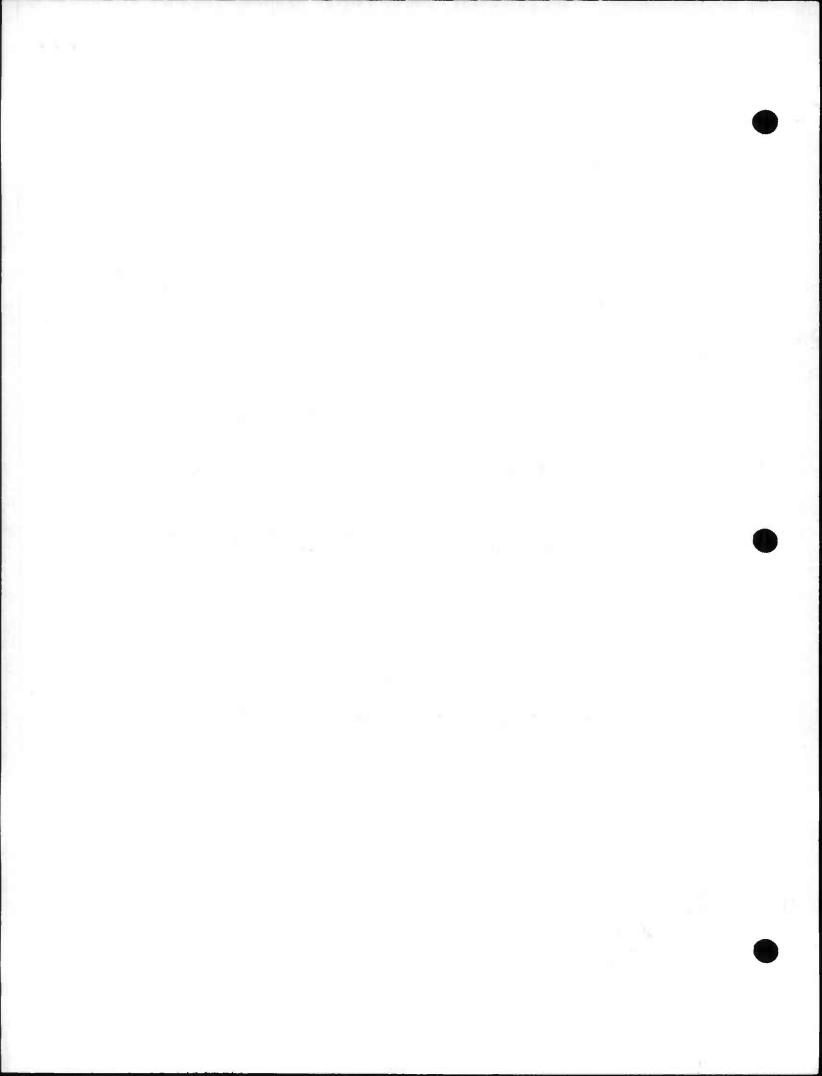
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - FOR STATE REGISTRAR | OF MARYLAND | | NT OF HEALT | | AL HYGIENE REG. NO. | | | | | |
|-------------------------------------|--|---|---|--|---|---|--|---|--|--|--|
| | 1. OECEDENT'S NAME (First, Middle, Last) | | | | | E OF DEATN | | 3. TIME OF DEATH | | | |
| | NANCY KING | | | | 8 MON | | 1994 | 3 22 | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | 8 AGE (four | s. last birthday) IF U | NDER 1 YEAR IF UN | | | | 1:30 P M NPLACE (State or Foreign | | | |
| | MONTHS DAYS HOURS MIN. (Month, Day, Year) | | | | | | | | | | |
| | 442-20-9056 1 72 YRS November 5, 1921 Mary 1 | | | | | | | | | | |
| | 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN | | | | | | | | | | |
| ö | Greater Baltimore Medical Center Towson Baltimor | | | | | | | | | | |
| ן ק | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | | | | | | | | | |
| DIRECTOR | | | 10c. CITY, 101 | VN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? | | | |
| | Maryland Carroll C | ounty | | Syl | esville | | | 1 TYES 2 NO | | | |
| ₹ I | 10e. STREET AND NUMBER | UMBER 101 | | | | | 10g. CITIZEN OF | WHAT COUNTRY? | | | |
| FUNERAL | Springfield Ho | | 21784 | i | U.S | . А. | | | | | |
| 5 | 11. MARITAL STATUS 12. WAS D | OF HISPANIC ORIG | | r No- 14, RAC | E American Indian. | | | | | | |
| | NA HE VES | S? 1 YES 2 | | If yes, specify Co | ben, Mexican, Puerti O Specify: | o Rican, etc.) | Spe | ck, White, etc. | | | |
| B | 3 Widowed 4 Divorced | , | | | opoury. | | | White | | | |
| COMPLETED | 15, DECEDENT'S EDUCATION | L OCCUPATION | 10 | b. KIND OF BUSI | NESS/INDUSTRY | | | | | | |
| | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1 | one during most of wo ed.) | rking | | | | | | | | |
| ᆲ | 4 | , , , , , , | N | / A | | | N/A | | | | |
| <u>₹</u> | 17. FATNER'S NAME (First, Middle, Last) | | N | | OTNER'S NAME (First | Middle Maides C | | | | | |
| | | | | 10. 1 | | | | | | | |
| 8 | Francis Hall 19a. INFORMANT'S NAME (Type/Print) | | | | | Linger | | | | | |
| 임 | | | | RESS (Street and Num | | mber, City or Town, | State, Zip Code) | | | | |
| | Springfield Hospital Sykesville, MD 27184 | | | | | | | | | | |
| | 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) 20c. LOCATION — City or Town, State | | | | | | | | | | |
| | Cemeton 3 Ramoval from Stata Cemetory, crematory or other place) Springfield Cemetery 9/11/1994 Sykesville, MD | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | |
| | > Blian 2.9 | Valal + | _ | HAIGHT | FUNERAL | HOME (P | .0. Box | 195) | | | |
| | | | | Sykesvi | 11e, MD | 21784 (| 410)-79 | 5-1400 | | | |
| | 23. PART I. Enter the diseases, or complication shock, or heart failure. List pniy p | ons that coused the | e deeth. Do not e line. | nter the mode of | dying, such as ca | rdiec or respire | story arrest, | Approximate Interval Between | | | |
| | | | | | | | | Onset and Death | | | |
| | disease or condition resulting in death) | epatic. | tailva | 2 | | | | 5 obus | | | |
| | a | DUE TO (OR AS A COL | SEQUENCE OF): | 1 (. | | | | 1000 | | | |
| 2 | PX | mbable | motos | Tatic CI | INCOL | | | | | | |
| 0 | Sequentially list conditions, if any, leeding to immediate | DUE TO (OR AS A CON | SEQUENCE OF): | vale C | N, CO. | | | | | | |
| Ā | cause. Enter UNDERLYING | | | | | | | | | | |
| ᇤ | CAUSE (Disease Dr injury that initiated events | DUE TO (OR AS A COM | NSEQUENCE OF): | | | | | | | | |
| EI | resulting in death) LAST | | | | | | | | | | |
| CERTIFICATION | d | | | | | | | | | | |
| AL | PART il. Other aignificent conditions contribu | ting to death but n | Dt resulting in th | PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WE | | | | | | | |
| | | | | | IEDP I | AVAILABLE PRIOR TO | | | | | |
| | | | | , | | PERFORM | | COMPLETION OF CAUSE | | | |
| EDIC | | | | | | 1 TYES 2 | | OF DEATH? | | | |
| MEDIC | | | | | | | | | | | |
| AN: MEDIC | DID TOBACCO USE CONTRI | BUTE TO CA | USE OF DE | ATH YES |] NO [] | 1 🗆 YES 2 | | OF DEATH? | | | |
| CIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL | | | ATH YES [| NO Check only | 1 🗆 YES 2 | | OF DEATH? | | | |
| YSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? / HOSPIT | | ОТ | ATH YES | OEATN (Check only | 1 YES 2 | | OF DEATH? | | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 IV Input 27. MANNER OF DEATN 288. I | FAL: lent 2 ER/Outpetlen | nt 3 DOA 4 D | 26. PLACE OF SURFINE S | OEATN (Check only Residence 6 - Ot | 1 YES 2 | NO NO | OF DEATH? | | | |
| Y PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Toppet 27. MANNER OF DEATN Netural 5 Pending | FAL: lent 2 - ER/Outpatlen | or 3 DOA 4 DOA 28b. TIME OF INJURY | 26. PLACE OF | OEATN (Check only Residence 6 Ot 28d. D | 1 YES 2 | NO NO | OF DEATH? | | | |
| B | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Input 27. MANNER OF DEATN Netural 5 Pending investigation 3 Suiciden 26a. F | FAL: lant 2 = ER/Outpatian DATE OF INJURY Month, Day, Year) PLACE OF INJURY — A | 28b. TIME OF | 28. PLACE OF HER: Nursing Nome 5 28c. INJURY AT WORK? 1 YES 2 | Pasidence 6 Ot 28d. D | 1 PES 2 | JURY OCCURED | OF DEATH? 1 YES 2 NO | | | |
| B | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Input 27. MANNER OF DEATN Netural 5 Pending investigation 3 Suiciden 26a. F | FAL: lant 2 ER/Outpatien DATE OF INJURY Month, Day, Year) | 28b. TIME OF | 28. PLACE OF HER: Nursing Nome 5 28c. INJURY AT WORK? 1 YES 2 | Pasidence 6 Ot 28d. D | 1 VES 2 | JURY OCCURED | OF DEATH? 1 YES 2 NO | | | |
| B | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | FAL: lent 2 ER/Outpatien DATE OF INJURY Month, Day, Year) PLACE OF INJURY — A building, atc. (Specify) | 28b. TIME OF INJURY | 26. PLACE OF | Residence 6 Ot 28d. D 28f. LC C | 1 PES 2 one) her (Specify) ESCRIBE HOW IN. OCATION (Street error by or Town, State) | JURY OCCURED d Number or Rural | OF DEATH? 1 YES 2 NO | | | |
| B | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | FAL: lant 2 ER/Outpatlan DATE OF INJURY Month, Day, Year) PLACE OF INJURY — A building, atc. (Specify) | 265. TIME OF INJURY | 28. PLACE OF | Residence 6 Ot 28d. D 10 NO 281. LC CC 28ca, and due to the c | 1 PYES 2 one) her (Specify) ESCRIBE HOW IN OCATION (Street arry or Town, State) ause(a) and manner | JURY OCCURED of Number or Rural oer se stated. | OF DEATH? 1 YES 2 NO Route Number, | | | |
| B | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | FAL: lant 2 ER/Outpatlan DATE OF INJURY Month, Day, Year) PLACE OF INJURY — A building, atc. (Specify) | 265. TIME OF INJURY | 28. PLACE OF | Residence 6 Ot 28d. D 10 NO 281. LC CC 28ca, and due to the c | 1 PYES 2 one) her (Specify) ESCRIBE HOW IN OCATION (Street arry or Town, State) ause(a) and manner | JURY OCCURED of Number or Rural oer se stated. | OF DEATH? 1 YES 2 NO Route Number, | | | |
| COMPLETED BY | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | FAL: lant 2 ER/Outpatlan DATE OF INJURY Month, Day, Year) PLACE OF INJURY — A building, atc. (Specify) | 265. TIME OF INJURY | 28. PLACE OF HERE: Nursing Nome 5 28c. INJURY AT WORK? 1 YES 2 factory, office | Residence 6 Ot 28d. D 10 NO 281. LC Cl | 1 PYES 2 one) her (Specify) ESCRIBE HOW IN OCATION (Street arry or Town, State) ause(a) and manner | JURY OCCURED d Number or Rural er as stated. dua to the cause | OF DEATH? 1 YES 2 NO Route Number, | | | |
| BE COMPLETED BY | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO IV Inpatt 27. MANNER OF DEATN Natural 5 Pending investigation 3 Suicide 6 Could not be detarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the billion of the could not be detarmined | FAL: lant 2 ER/Outpatlan DATE OF INJURY Month, Day, Year) PLACE OF INJURY — A building, atc. (Specify) | 265. TIME OF INJURY | 28. PLACE OF HERE: Nursing Nome 5 28c. INJURY AT WORK? 1 YES 2 factory, office | Residence 6 Ot 28d. D 28f. LC ccc, and due to the ccured at the time, de | 1 PYES 2 one) her (Specify) ESCRIBE HOW IN OCATION (Street arry or Town, State) ause(a) and manner | JURY OCCURED d Number or Rural er as stated. dua to the cause | OF DEATH? 1 YES 2 NO Route Number, (s) and menner as stated. | | | |
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| BE COMPLETED BY | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | PAL: lent 2 ER/Outpatien DATE OF INJURY Month, Day, Year) PLACE OF INJURY — A building, atc. (Specify) a best of my knowledge asis of axaminstion and | 28b. TIME OF INJURY 1 thome, farm, street, e, daeth occurred at 3/or investigation, in | 28. PLACE OF HERE: Nursing Nome 5 28c. INJURY AT WORK? 1 YES 2 factory, office | Residence 6 Ot 28d. D 28f. LC ccc, and due to the ccured at the time, de | 1 PES 2 one) her (Specify) ESCRIBE HOW IN CATION (Street en by or Town, State) sause(a) and mannate and place, and | JURY OCCURED of Number or Rural oer se stated. due to the cause 29d. DATE SIGNE 8-3 | OF DEATH? 1 YES 2 NO Route Number, (e) and menner as stated. D (Month, Day, Year) | | | |

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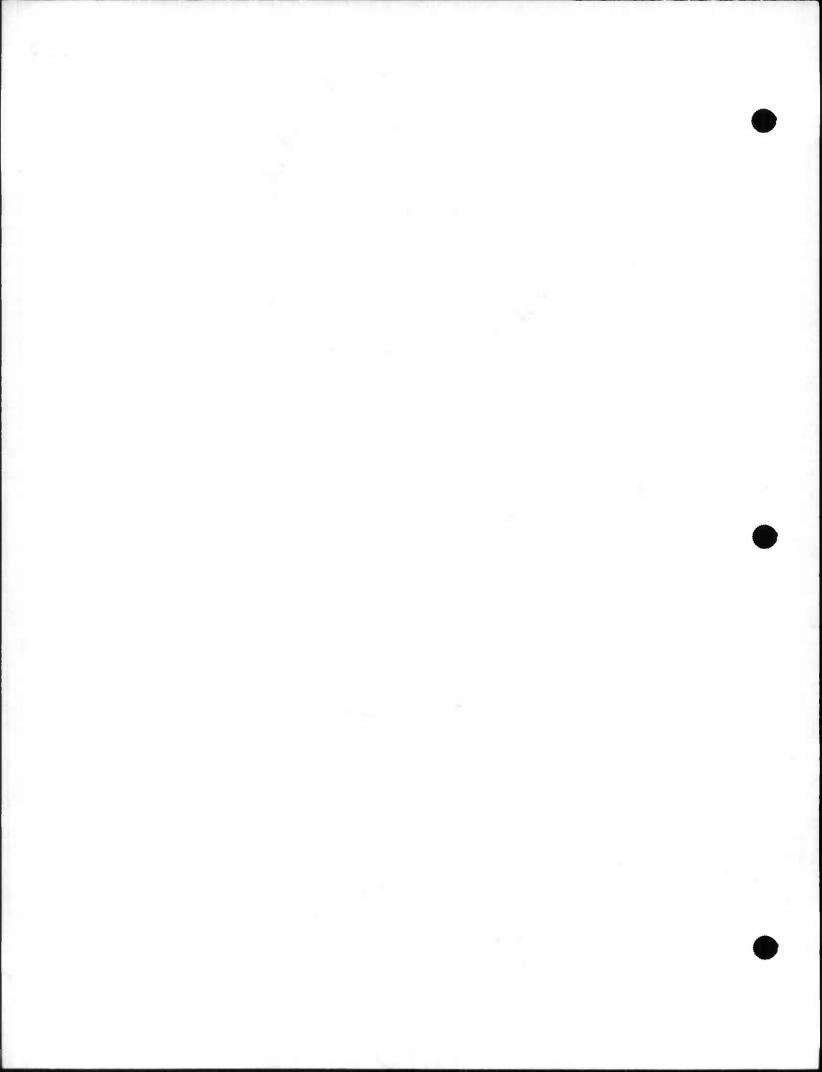
| | | FOR STATE REGISTRAR | STATE OF MARYL | AND / E | DEPARTMI RTIFICA | ENT OF H | HEALTH AND | MENTAL HYGIEN REG. NO | | |
|---|---------|---|---|-----------------------------|--------------------------------|----------------|--------------------------------|--|-------------------|---|
| | 3 | 1. OECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF DEATH MONTH DA | | 3. TIME OF DEATN |
| | 7 | Catherine M. | | | | | | 9 1 | C | 4 2:30 A.M. M |
| | 9 | 4. SOCIAL SECURITY NUMBER | | (In yrs. lest t | MONT | THS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTN (Morith, Day, Year) | 0. | BIRTNPLACE (State or Foreign Country) |
| should | | 217-50-9391 9e. FACILITY NAME (If not institution, give st | | 0 | YRS. | ATV TOWN | TO A CONTINUE OF DE | 4/17/04 | 1 20111 | Canada |
| i, 2, 3 sho | CTOR | Meridian Nursing | | Rave | | | OWSON: Ba | | | timore Co. |
| L. Pages 1 | DIREC | 10a. STATE 10b. COUNTY | imore County | 17 | 10c. CITY, TOO Balti | | TION | - | | 10d. INSIDE CITY LIMITS? 1 YES 2XXNO |
| permit. | | 10e. STREET AND NUMBER | more cours | <u>y</u> | Darva | | 1. ZIP CODE | | 10g. CITIZE | N OF WHAT COUNTRY? |
| TS. | FRAL | 8720 Emge Road 21234 U.S.A. | | | | | | | S.A. | |
| 5-0020 nding physician. ss the burlat-transit | BY FUNI | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR DO | N U.S. ARMI 2 NO ATES | ED | If yes, sp | | NIC ORIGIN? (Specify Yearin, Puerto Rican, atc.) | or No 14 | Black, White, atc. Specify: White |
| affe affe | TED | 15. DECEDENT'S EDUC (Specify only highest grade | CATION completed) | (Give | EDENT'S USUA kind of work d | lone durina ma | ON ost of working | 16b. KIND OF BUS | SINESS/INDUS | TRY |
| the hospital or detached for a | APLET | Elementary/Secondary (0-12) 10th Grade | College (1-4 or 5+) | | o NOT use retir lousewi | | | Home | Maker | |
| YLAND by the hospit be detached at once. | COMPL | 17. FATHER'S NAME (First, Middle, Last) | vh+vr | | | | 18. MOTHER'S NA | ME (First, Middle, Meiden | Sumeme) | |
| T P P D | BE | Patrick Garrauc | incy | 19b. | MAILING ADD | RESS (Street e | | rine Henr | 4 | oria) |
| 5 5 | 유 | Albert G. McCullo | ough | | | | | Baltimore | | |
| Ber Sp. | | 20e. METNOD OF DISPOSITION 1 To Burial 2 Cremation 3 Ramo 4 Donation 5 Other (Specify) | oval from Stata cem | netery, creme | DDATE OF DIS | lace) | | | | y or Town, State |
| AL I IM death. Page funeral direct. | | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | wonse | riage | 22. NAME A | ND ADDRESS OF FA | CILITY | | e. Maryland |
| BAL I ther death. the funera oval. al examin | | Xichard | E. Xas | nel | | | | Hgwy, Balt | imore | Md 21225 |
| hours after bed in by the or removal | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heert fallure. Liet only one cause on each line. Approximate interval Between | | | | | | | | |
| the the | | IMMEDIATE CAUSE (Final disease or condition | Macke | 0.11 | • | Ca | 05 | run be | Ry | Onaet and Death |
| with plete crem | | resulting in deeth) | DUE TO (OR AS A | CONSEQU | ENCE OF): | | CAIO | ryo po | | |
| exect and to but | CATION | Sequentially list conditions, if any, leading to immediate b. Due to (OR As A CONSEQUENCE OF): | | | | | | | | |
| ficate be physician be prior i | ICA | cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | |
| th certification of other | CERTIFI | thet initieted events resulting in death) LAST | DUE TO (OR AS A | A CONSEOU | ENCE OF): | | | | | |
| 2 88 3 | AL C | PART ii. Other eignificant condition | e contributing to deeth b | out not res | sulting in the | e underlyin | g cause given in | | | 24b. WERE AUTOPSY FINDINGS |
| that the by the any | EDIC/ | Diabe | ten we | le: | lus | | | 1 TYES 2 | | AMPLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| of of the | Σ | 1 Tes 2 No | | | | | | | | 1 TES 2 NO |
| has the Dept | SICIAN: | DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL | CONTRIBUTE TO | CAUS | E OF D | | YES NO | | | |
| - F 2 % 5 | SIC | EXAMINER? 1 YES 2 X NO | HOSPITAL: 1 Inpatient 2 ER/Ouip | patient 3 | DOA AT | | | 6 Other (Specify) | | |
| This ce with the the d. | РНУ | 27. MANNER OF OEATH 1 Natural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | 28c. INJ WO | IURY AT DRK? | 28d. DESCRIBE HOW I | NJURY OCCU | RED |
| After After death | ВУ | 2 Accident Investigation 3 Suicide 8 Could not be | 26e. PLACE OF INJURY | — At home | e, ferm, street, | M 1 1 | | 281. LOCATION (Street | and Number or | Rural Route Number, |
| 1 | ETED | 4 Nomicide determined | building, etc. (Spec | city) | | | | City or Town, State) | | |
| | COMPL | | CIAN: To the best of my know R: On the basis of exemination | | | | | | | euse(e) and manner as stated. |
| TO THE HE TO THE PL De filed will | BE | 296. SIGNATURE AND TITLE OF CERTIFIER | CO RA | · P. | PZI | | 29c. LICENSE NUI D08358 | | 29d. DATE S ▶ 9/1 | IGNED (Month, Day, Year) |
| | 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | ATH (ITEM | | d | | | | |
| | | 31. DATE ENED DAOPP. DAY, PERO A | 32. REGISTRAR'S SIGN | ATURE | | | | _ | | |



30. NAME AND ADDRESS OF PERSON WHO COMPLETE VALUE OF THE STATE OF THE

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
rselas, M. J. 9440

| | | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPAI CERTIF | RTMENT O | F HEALTH | AND MI | ENTAL HYGIEN REG. NO | | |
|--|-------------|---|--|--|-------------------------|---------------------------|-------------------------------|---|-------------------|---|
| | | 1. DECEDENT'S NAME (First, Middle, Las | D 1. 14 | foot - | 1r. | | 2 | MONTH 9 | ~2 94 | 3. TIME OF DEATH |
| | K | 4. SOCIAL SECURITY NUMBER 227-04-0477 | | (in yrs. last birthday) YRS. | IF UNDER 1 YE MONTHS DA | | See. | Month, Day, Year) | | BIRTHPLACE (State or Foreign Country) |
| pinous | | 9e. FACILITY NAME (If not institution, give | street end number) | | 9b. CITY, TO | WN OR LOCAT | | | 9c. COUNTY | |
| 2.3 | СТОВ | Southern Marylan | d Hospital Ce | nter | | | | | | Georges |
| Pages 1, | ш | 10e. STATE 10b. COUR | ITY | 10c. CF | TY, TOWN OR L | OCATION | | | | 10d. INSIDE CITY |
| permit. Pa | DIR | | ne | Fa | lls Ch | | | | | LIMITS? 1X YES 2 NO |
| | ERAL | 100. STREET AND NUMBER | 109 Tinners Hill | | | 22046 | _ | | U.S.A | OF WHAT COUNTRY? |
| 020 physician. burial-transit | FUN | 11. MARITAL STATUS 1 Never Merried 2 Merried | 12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D | 2 X NO | If ye | DECENDENT | OF HISPANIC en, Maxicen, I | ORIGIN? (Specify Ye Puerto Ricen, etc.) | | RACE — American Indian, Black, White, etc. |
| 215-0020 attending physic se as the burial | ВУ | 3 Widowed 4 Divorced | 1 | | | - 123 Z E3 NO | зреспу. | | | Black |
| or afte | ETED | 15. DECEDENT'S EI (Specify only highest gra | de completed) | 16e. DECEDENT'S (Give kind of life, Do NOT u | work done durin | PATION g most of worki | ing | 16b. KIND OF BU | SINESS/INDUST | RY |
| O S S S S S S S S S S S S S S S S S S S | E COMPLE | Elementary/Secondary (0-12) | College (1-4 or 5 +) | Mana | | | | Foot I | Locker | |
| YLA by the be det | | 17. FATHER'S NAME (First, Middle, Last) James R. Lightfo | ot, Sr. | | | | | Jones | Surname) | |
| retained by 5 should be notified al | TO B | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (St | reet and Numbe | or or Rural Rou | rte Number, City or Tow | m, State, Zip Coo | fe) |
| 60 m | F | Pearl J. Morris | | 109 I | <u>inners</u> | Hill, | fall | s Church, | Va. 2 | 2046 |
| | | 20a_METHOD OF DISPOSITION 1 Table 2 Cremation 3 Re 4 Donation 5 Other (Specify) | moval from Stata 20b | PLACE AND DATE the start of the | of DISPOSITIO | N (Name of | 0 | | CATION — City | |
| Page 6 m id director, | | 21. SIGNATURE OF FUNERAL SERVICE | | Galloway | 22. NAN | E AND ADDRE | SS OF FACIL | /7/94 Fal | Tuneral | Home, Inc. |
| ex er de | | · Bernar | 10.A | mer | 891 | 4 Quar | ry Rd | . Manassa | as, Va. | 22110 |
| urs af in by r remo | | 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. Approximate interval Between | | | | | | | | |
| ly fille ation. | | iMMEDIATE CAUSE (Final disease or condition resulting in death) | Brain a | lenth. | | | | | | Onset and Des |
| executed with and complete o burial, crem | z | | DUE TO (OR AS A | CONSEQUENCE | 17771/ | 1/2 | intro | veritrin | ilas | ZYhra |
| UX of the control of the brown | RTIFICATION | if any, leading to immediate | | | | | | | | |
| certificate ding physic lygiene pri | FIC | CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| 7 5 5 0 | ERTI | resulting in death) LAST | d | | | | | | | |
| the death the attend Mental H Injury, or | 0 | PART II. Other significant conditi | ona contributing to death b | ut not reaulting | in the under | iying cauae | given in Pa | irt i. 24a. WAS AN | AUTOPSY | 24b. WERE AUTOPSY FINDING |
| T that the see of the | EDICA | | | | | | | PERFOI | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| Sign Sign Sign Sign Sign Sign Sign Sign | MED | | | | | | | | | OF DEATH? |
| L law | AN: | DID TOBACCO USE | CONTRIBUTE TO | CAUSE OF | DEATH | YES [| NO | P | | |
| e at the A | PHYSICI/ | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: 1 1 Inputient 2 ER/Outp | patient 3 DOA | OTHER: | 6. PLACE OF I | | Other (Specify) | | |
| PHY His S | | 27. MANNER OF DEATH 1 Natural 5 Pending Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TII | JURY | WORK? | | 6d. DESCRIBE HOW | INJURY OCCUR | ED |
| TTENDING TOR: After after death 28 is ma | ED BY | 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined | 28a, PLACE OF INJURY | — At home, farm, | street, fectory, | office | 2 | 81. LOCATION (Street City or Town, Stete | end Number or F | Tural Route Number, |
| B BBB | LET | 29a. CERTIFIER 1 CERTIFYING PH | /SICIAN: To the best of my know | ledge death occur | red at the time | data and place | a and due to | the cause/e) and me | mar so stated | - |
| 選 式に = | OMP | | NER: On the basis of examination | | | | | | | use(e) and manner ee stated. |
| A STATE OF THE STA | BE CO | 29b. SIGNATURE AND TITLE OF STREET | who MI | Ů. | | 29c. LIC | ENSE NUMBE | - | 29d. DATE SI | TO OUT YOUR |



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| DALIIMORE, MARTLAND ZIZIS-UUZU | ited within hours after death. Page 6 may be retained by the hospital or attending physic | |
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DIMISION OF VITAL RECORDS, P.O. BOX 68760

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| ATT NOING PHYSICIAN: The law requires that the death certificate be executed within a hours after | thic |
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| gned by the attending physician and comi sith and Mental Hygiene prior to bunal, or | n and completely filled in by the to bunal, cremation, or remove | e funeral director, p. | y be retained by page 5 should be | the nospital or attendir detached for use as the | ng prysician. he burial-transit permit, Pagi | es 1, 2, 3 shou |
|--|--|--|--|--|---|---------------------------------------|
| After this certificate has been similar death with the State Dept. of He | ACING CITIZALAN. THE OWN EQUIPS THAT WE GEATH ORDINATE OF THE ATTENDED BY THE ATTENDED PHYSICIAL CHAIN WITH THE STATE DEPT. OF HEAITH AND MENTAL HYGIERE PRIOR | Admits of the confidence with the form requires the controlled by the attending physician and completely filled in by the central physician and completely filled in by the central controlled by the central physician and completely filled in by the central controlled by the cent | Advance in the law requires that are been countain and executed writings and obeding a first or that the secrificate has been signed by the attending physician and completely filled in by the funeral director, print the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | voring this control of the control o | ed for | ed for |
| The Start This certificate has been significant with the State Dept. of He | The Adrer this certificate has been signed by the attending physicial the death with the State Dept. of Health and Mental Hydiene prior | The notion of this cardificate has been signed by the attending physician and completely filled in by the strength with the State Dept. of Health and Mental Hydiene prior to bunal, cremation, or remova | or months in this cartificate has been signed by the attending physician and completely filled in by the funeral director, it is death with the State Dept. of Health and Mental Hyglene prior to bunal, cremation, or removal. | to drive this locker, the law quotes that we obtain contract are executed within-2 in the best of they be treatined by the attending physician and completely filled in by the funeral director, page 5 should by the direction physician and completely filled in by the funeral director, page 5 should be a death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | ed for | pital or attendir ed for use as th |
| After this certificate has been significate with the State Dept. of He | After this certificate has been signed by the attending physicial certificate has been signed by the attending physicial certificate has been signed by the attending physicial certificate high with the State Dept. of Health and Mental Hydiene prior | After this certificate has been signed by the attending physician and completely filled in by the certificate has been signed by the attending physician and completely filled in by the certificate has been signed by the Attending physician to bunal, cremation, or remove | igned by the attending physician and completely filled is eath and Mental Hygiene prior to burial, cremation, or | The control of the co | ed for | pital or attendir ed for use as th |

| | REGISTRAR CERTIFICATE OF DEATH REG. NO. | | | | | | | | | |
|---------------|--|--|--|--|--|--|--|--|--|--|
| | 1. OECEDENT'S NAME (First, MIDDIN, List) 2. DATE OF DEATH MONTH DAY YEAR 1. OECEDENT'S NAME (First, MIDDIN, List) 2. DATE OF DEATH MONTH DAY VEAR | | | | | | | | | |
| | 9 94 11.22 7 | | | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 1 | | | | | | | | | |
| DIRECTOR | 98. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DEATH 96. COUNTY OF DEATH | | | | | | | | | |
| ECT | RESIDENCE OF DECEDENT | | | | | | | | | |
| | MD. BALTIMORG PERKY HALL 1 VES 2 (14 NO | | | | | | | | | |
| FUNERAL | 9454 SOURN COURTS DRIVE 21236 U.S.A. | | | | | | | | | |
| BY FUI | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 1 Never Married 2 Merried 1 PSP. GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No- It yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. RACE — American Indian, Bleck, Whita, etc. Specify: 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No- It yes, specify Cuban, Maxican, Puerto Rican, atc.) 16. RACE — American Indian, Bleck, Whita, etc. Specify: 17. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No- It yes, specify Cuban, Maxican, Puerto Rican, atc.) 18. RACE — American Indian, Bleck, Whita, etc. Specify: 19. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No- It yes, specify Cuban, Maxican, Puerto Rican, atc.) | | | | | | | | | |
| ED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working) 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | |
| COMPLETED | Elamentary/Secondary (0-12) College (1-4 or 5+) PLUMBING PLUMBING | | | | | | | | | |
| COM | 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | | | |
| BE | JOHN G MARTIN SR. ELIZABETH DOEMLING | | | | | | | | | |
| 2 | 196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Plural Poute Number, City or Town, State, Zip Code) 4925-27 BECAIR RD, BAUTO. MD. 21206 | | | | | | | | | |
| | 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of | | | | | | | | | |
| | 1 P Burisi 2 Cremation 3 Removal from State Cemetery, organizatory or other place Cemetery, Organization of Conference Co | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE EUGENE CONTROL CONT | | | | | | | | | |
| | 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, euch as cerdiac or reepiretory arrest, Approximate ahock, or heart failure. List pnly one cause on each line. | | | | | | | | | |
| | IMMEDIATE CAUSE (Final disease or condition CAUSTAIN CAUSE) | | | | | | | | | |
| | resulting in deeth) e. Due to (or as a consequence of): | | | | | | | | | |
| z | 1SCHEMIC BOWER 5 DAYS | | | | | | | | | |
| TIO | Sequentially liat conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury. | | | | | | | | | |
| S | | | | | | | | | | |
| CERTIFICATION | that Initiated eventa resulting in deeth) LAST d. | | | | | | | | | |
| - 1 | PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | | |
| DICAL | PERFORMED? AMAILABLE PRIOR TO COMPLETION DF CAUSE | | | | | | | | | |
| | DF DEATH? | | | | | | | | | |
| ÿ | | | | | | | | | | |
| S | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSFITAL: OTHER: | | | | | | | | | |
| PHYSICIAN: ME | 1 Vinpatiant 2 ER/Outpatiant 3 OA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28b. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED | | | | | | | | | |
| | 1 Natural 5 Pending (Month, Day, Year) INJURY WORK? M 1 YES 2 NO | | | | | | | | | |
| ED BY | 2 Accident investigation 3 Suicide a Could not be building, atc. (Specify) 28s. PLACE OF INJURY — At home, farm, atreat, factory, office 28s. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| | 29e. CERTIFIER (Check only (Check only 1) CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the ceuse(s) and manner ea stated. | | | | | | | | | |
| COMPLETED | (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(a) and manner as stated. | | | | | | | | | |
| BE | 296. SIGNATURE AND TUTLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) DEPT. 3, 1994 | | | | | | | | | |
| 2 | STORMA , MD P-07618 DEPT. 3, 1994 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | |
| | KOFI OWUSH-BOAITEY GOOD SAMARITAN HUSPITAL LOCHRAVEN BLVD BALTIMON | | | | | | | | | |
| | 31. DACE FILED (Month? Dannyber). 32. REGISTRAR'S SIGNATURE | | | | | | | | | |
| | SEP 1 1994 John Sinder Rudale | | | | | | | | | |

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| DIVISION | |
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| G PHYSIGIAN: The law requires that the death certificate be executed within Za nours after death. Page 6 may be retained by the hospital or attending physician. | |
|---|--|
| er this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | |
| ith with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | |
| and an illume many informs on salara bearings accorded to many land and an accorded as a sality of an accorded | |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLAN | ID / DEPART | MENT OF I | IEALTH AND | MENTAL HYGIENI REG. NO. | E | | | |
|--|---|---|--------------------|----------------------|--------------------------------|--|----------------------------------|--------------------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | |
| | James John Mille | r | | | | 9/ 5/ | 1994 | м | | |
| | I 220-20-2651 I | 1 K M 2 □ F 64 | | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Mooth, Day, Year) 4/6/30 | a. BIRTH | IPLACE (State or Foreign 7) 7) | | |
| _ | 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | | | |
| DIRECTOR | 5009 Gateway Ter | | Baltir | nore | | | | | | |
| DIRE | MD Bal | timore | rbutus | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | | |
| FUNERAL | 10e. STREET AND NUMBER 10f. ZIP CODE | | | | | | 10g. CITIZEN OF V | VHAT COUNTRY? | | |
| 🖫 | 5009 Gateway Terrace 21227 | | | | | | U.S. | Α. | | |
| BY FU | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 9/2/52 - 6/20/54 13. WAS DECENDENT OF HISPANIC ORIGIN If yes, specify, Cuban, Mexican, Puarto II YES, GIVE WAR OR DATES 1 YES 2 NO Specify: | | | | | | or No- 14. RACI Black Spec | - American Indian, k, White, etc. | | |
| 日日 | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | | | | | | |
| COMPLETED | Elementary/Secondary (0-12) | | ist or working | | | | | | | |
| ₽ | 12 Firefighter | | | | | | | Government | | |
| | 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Gerald Francis Miller Cora McClain | | | | | | | | | |
| B | 19a. INFORMANT'S NAME (Type/Print) | IIIer | Tank Man min a | 222222 | · | | | | | |
| 임 | 196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town. State, Zip Code) Anna Miller 5009 Gateway Terrace, Arbutus, MD 21227 | | | | | | | | | |
| | 20er METHOD OF DISPOSITION 1 D Burdel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, crematory or other place) 20c. LOCATION — City or Town, State | | | | | | | | | |
| | Meadowridge Memorial Park 9/8 Dorsey, Maryland 21. SIGNATURE OF PUNERAL SERVICE LICENSEE Meadowridge Memorial Park 9/8 Dorsey, Maryland 22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home, Inc. | | | | | | | | | |
| Ambrose F 1328 Sulphur Spring Road, | | | | | | | Funeral d, Arbut | Home, Inc. us, MD 21227 | | |
| | 23. PART I. Enter the disesses, or co | mplications that caused the | ne death. Do no | | | | | Approximate | | |
| | | Corbro un | ocular | occi | dent | | | Interval Between Onset and Dasth | | |
| CERTIFICATION | DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initisted avents resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| MEDICAL | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDS TO COMPLETED OF CAUSE OF DEATH? | | | | | | | | | |
| N: M | DID TOBACCO USE CO | ONTRIBUTE TO C | AUSE OF | DEATH Y | ES N | 20 | | 1 - YES 2 1000 | | |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 26. P | LACE OF DEATH (C | theck only one) | | | | |
| IYS | 1 YES 2 NO 27. MANNER OF DEATH | 1 Inpatient 2 ER/Outpatie | ent 3 DOA | I ☐ Nursing Hor | e 5 Realdence | | | | | |
| Y PHY | Netural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME INJU | RY W | IURY AT ORK? YES 2 NO | 28d. DESCRIBE HOW IN | RIBE HOW INJURY OCCURED | | | |
| ЕТЕВ ВУ | 2 Accident Investigation 3 Suicide 8 Could not be determined | 28e. PLACE OF INJURY — building, atc. (Specify) | At home, farm, atr | reet, factory, offic | • | 28f. LOCATION (Street a City or Town, State) | nd Number or Rural I | loute Number, | | |
| COMPLE | | AN: To the beat of my knowled: On the Masia of examination a | | | | | |) and manner as stated. | | |
| BE | 296. SIGNATURE AND TITLE OF CENTIFIER | ly mi | 3 | | 29c. LICENSE NO | JMBER 587 | 29d. DATE SIGNED | (Month, Day, Year) | | |
| ТО | 39/NAME/AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEATH | (ITEM 27) (Type, F | fon | Aus | Beth. | ms = | 4229 | | |
| | 31. DASEP (1017) 1994 | 32. REGISTRAR'S SIGNATU | PELL | - | | | | / | | |



0.00



FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1 - STATE REGISTRAR | | CEF | | | DEATH | III LIVE | REG. NO | - | | |
|------------------------------------|--|---------------------|---|--|--|-------------------------------------|---|--|------------------|--------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) Angele Marie Michaud | | | | | | | | | | 3. TIME OF DEATH |
| | ANGELE MICHAUD DOOLEY | | | | | | SEP | | 1994 | | 11:30 AM |
| | 4. SOCIAL SECURITY NUMBER 5. | SEX 6. A | GE (In yrs. last bi | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE C | F BIRTH | | 6. BIRTI | HPLACE (State or Foreign |
| | 170-38-7223 | ☐ M 2 🔣 F | 49 | YRS. | ONTHS DAYS | HOURS MIN, | JAN | Day, Year) 20. | 1945 | Count | CHIGAN |
| | 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | DEATH |
| DIRECTOR | 8545 MARYBETH WAY ELLICOTT CITY HOWARD | | | | | | | | | OD | |
| EC | 10e. STATE 10b. COUNTY | | | 10c. CITY, TOWN OR LOCATION | | | | | 10d. INSIDE CITY | | |
| 0 | MARYLAND HO | YLAND HOWARD | | ELLICOTT CITY | | | | | | LIMITS? | |
| BY FUNERAL | 10e. STREET AND NUMBER | | | | 1 | 10g. CITIZEN | | | IZEN OF V | WHAT COUNTRY? | |
| | 8545 MARYBETH WAY | | | | | 43 U. | | | U.S. | A | |
| 5 | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARM | | | D | | NIC ORIGIN? (Specify Yea or No. 14. | | | 14. RAC | E American Indian. | |
| | 1 Never Married 2 Married FORCES? 1 YES 2 Married IF YES, GIVE WAR OR DATES | | | | If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: WHIT | | | | | | |
| | 15. DECEDENT'S EDUCATION 18a. DEC | | | CEDENT'S USUAL OCCUPATION | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| COMPLETED | (Specify only highest grade completed) (Ghille. Elementary/Secondary (0-12) College (1-4 or 5+) | | | kind of work done during most of working Do NOT use retired.) | | | | | | | |
| <u>a</u> | | | | | UITMENT ADMINISTRATOR LAW FIRM | | | | | | |
| 3 | 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Meiden Surname) | | | | | |
| Bit C | JOSEPH MICHAUD | | | | ROSEMARY BONE | | | | | | |
| | 19a, INFORMANT'S NAME (Type/Print) 19b. | | | | G ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) | | | | | | |
| 오 | ORIN W. DOOLEY 85 | | | | 45 MARYBETH WAY, ELLICOTT CITY, MD. 21043 | | | | | | 1043 |
| | 20a. METHOD OF DISPOSITION 20b. PLACEAN | | | | DISPOSITION // | | DATE 20c. LOCATION — City or Town, State | | | | |
| | | | | | T CREM | 9/6 BALTIMORE, MARYLAND | | | | | |
| | 21. BIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | | THICT LIMIT |
| | 14:00 A | 550 | BRADLEY-ASHTON FUNERAL HOME, INC. 2134 WILLOW SPRING RD., DUNDALK, MD. 21222 | | | | | | | | |
| Y PHYSICIAN: MEDICAL CERTIFICATION | 23. PART I. Enter the diseases, or complicatione that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence of): | | | | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | |
| | 0 | | | | | | | | | | |
| | PART II. Other significant conditions contributing to death but not rea | | | | | | | Pert I. 24a. WAS AN AUTOPSY PERFORMED? | | 240 | o. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO | | | | | | | | | | |
| | 25. WAS CASE REFERRED TO MEDICAL EVAMINED 26. PLACE OF DEATH (Check only one) | | | | | | | | | | |
| | | ☐ Inpetient 2 ☐ ER/ | Outpatient 3 🗆 | | OTHER: I Nursing Ho | me 5 🗆 Raeldenca | 8 🗆 Other | (Specify) | | | |
| | 27. MANNER OF DEATH 1 | | | 86. TIME INJU | TIME OF 28c. INJURY AT 28d. OESCRIBE HOW INJURY OCCURED WORK? M 1 YES 2 NO | | | | | | |
| ED BY | | | | ne, farm, street, tactory, offica | | | 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| <u> </u> | 29a. CERTIFIER CERTIFIER DUNGE | | | | | | 1 | - | | | |
| COMPLETED | (Check of the cause(a) and menner as stated. (Check of the cause(a) and menner as stated. (Check of the cause(a) and menner as stated. (Check of the cause(a) and menner as stated. (Check of the cause(a) and menner as stated. | | | | | | | | | | |
| H | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 9 2 9 4 | | | | | (Month, Day, Year) | |
| ٥ | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) Prashant Shukla University of Maryland Cancer Center 225. Greene St. Baltimore mD 21201 | | | | | | | | | | |
| | 31. DATE FILED (Month, On. Year) 1994 32. REGISTRATIC SIGNATURES 31. DATE FILED (Month, On. Year) 1994 | | | | | | | | | | |
| | 7/3/4 | 9 | | | | | | | | | |

or physician. BALTIMORE, MARYLAND 21215-0020 hours after death. Page 6 may be retained by the host TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a found after death. Page 6 may be retained by the hous TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detained filled within 72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-16 Rev 1/89

U. T

BALTIMORE, MARYLAND 21215-0020

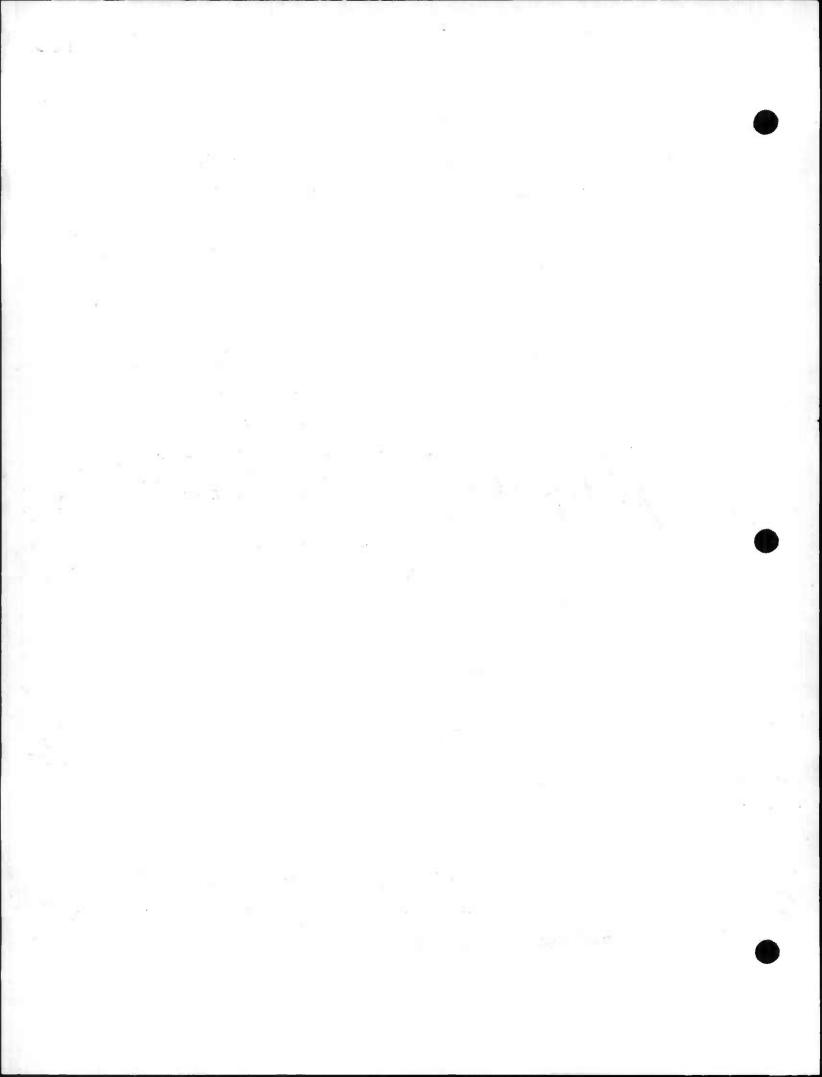
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within to The Funds of may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

| TE | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
|--------|---|----------|
| ISTRAR | CERTIFICATE OF DEATH | REG. NO. |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAND | / DEPARTM | ENT OF H | EALTH AND DEATH | MENTAL HYGIEN | | | | | | | |
|-------------------|--|---|--------------------------------|---------------------------|--------------------------------|--|-------------------|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH MONTH D | 3. TIME OF DEATH | | | | | | |
| | | MURRAY | | | | 9 | 1 0 | 74 2:40 PM | | | | | |
| | | 6. AGE (In yrs. I | | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | BIRTHPLACE (State or Foreign Country) | | | | | |
| | 9a. FACILITY NAME (If not institution, give street | 11 / 2 | | CITY, TOWN O | R LOCATION OF D | June 8, 1 | | Maryland r OF DEATH | | | | | |
| CTOR | Good Samaritan Ho | spital | | Bal | timore | | | | | | | | |
| 답 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10c. CITY. TO | OWN OR LOCAT | | | | 10d. INSIDE CITY | | | | | |
| DIRE | Maryland | | | altimo | | | | LIMITS? | | | | | |
| | 10e, STREET AND NUMBER | | | | ZIP CODE | | 10g. CITIZEI | N OF WHAT COUNTRY? | | | | | |
| FUNERAL | 6301 Harford Rd. 21214 USA | | | | | | | | | | | | |
| 5 | 11. MARITAL STATUS 12 1 Never Married 2 X Married | 2. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 | NO | If yea, spe | cify Cuban, Maxico | NIC ORIGIN? (Specify Year, Puarto Rican, stc.) | s or No- 14 | I. RACE — American Indian, Black, White, atc. | | | | | |
| BY | 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR DATES | | 1 TYES | 2X NO Specif | /y: | | White | | | | | |
| 18 | 15. DECEDENT'S EDUCAT (Specify only highest grade con | npleted) | DECEDENT'S USU | done during mos | N st of working | 16b, KIND OF BU | SINESS/INDUS | TRY | | | | | |
| PLET | Elamentary/Secondary (0-12) | College (1-4 or 5+) | ife. Do NOT use rel Homemak | | | Or my II o | | | | | | | |
| once. | 17. FATHER'S NAME (First, Middle, Last) | I | Tomenax | er | 16. MOTHER'S NA | Own Ho | | | | | | | |
| e 111 | Daniel Sapanero | | | | Maria | | 1111 | | | | | | |
| must be notified | 19a. INFORMANT'S NAME (Type/Print) | 1 | | | nd Number or Rural | Route Number, City or Tow | vn, State, Zip Co | ode) | | | | | |
| De no | Gail Burton | | | | Rd., Ald | | 2001 | | | | | | |
| unst | 20a. METHOD OF DISPOSITION 1 | I from Stata 20b. PLACI | erematory or other to Mount | ISPOSITION (Nai place) | tors | | | Cify or Town, State | | | | | |
| luer I | 21. SIGNATURE OF FUNDRAL SERVICE LICEN | | ii riodiic | 22. NAME AN | D ADDRESS OF FA | CILITY | ltimore | 3, MD | | | | | |
| examiner | ALTENBURG FUNERAL HOME, P.A. | | | | | | | | | | | | |
| medical | 23. Par Enter the diseases or complications that ceused the daeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between | | | | | | | | | | | | |
| E B | shock, or heart failure. List only one cause on sech line. IMMEDIATE CAUSE (Final | | | | | | | | | | | | |
| # # | disease or condition resulting in death) | Intraces | ebra | V HI | mer | hage | | 14 hours | | | | | |
| eve : | | DUE TO (OR AS A CONS | EOUENCE DF): | -1000 | 2 (, ,) | | | 40 yrs. | | | | | |
| TO TO | Sequentially list conditions, If any, leading to immediate | DUE TO (DR AS A CONS | EQUENCE OF): | w. | 20170 | | | , , | | | | | |
| ICA] | Cause. Entar UNDERLYING CAUSE (Disease or Injury | | | | | | | | | | | | |
| CERTIFICATION | that initiated eventa resulting in death) LAST | DUE TO (OR AS A CONS | EOUENCE OF): | | | | | | | | | | |
| injury, or | d | | | | | | | | | | | | |
| | PART II. Other algnificant conditions of | ontributing to death but not | raaulting in th | na undarlying | cause given in | Part I. 24a, WAS AN PERFOI | | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | | | | | |
| ws any EDIC | | | | | | 1 TES 2 | NO | OF DEATH? | | | | | |
| e ≥ | | | | | | — i | | 1 TYES 2 THO | | | | | |
| item 23 SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | ACE OF DEATH (C) | neck only one) | | | | | | | |
| | 1 □ YES 2 □ NO 1 | OSPITAL: Inputient 2 - ER/Outputient | | HER: Nursing Home | 5 - Rasidenca | 6 Other (Specify) | | | | | | | |
| P. F. | 27. MANNER OF DEATH 1 Natural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY | WO | RK? | 28d. DESCRIBE HOW | INJURY OCCUP | RED | | | | | |
| | 2 Accident Investigation 3 Suicide & Could not be | 26a. PLACE OF INJURY — At I | homa, farm, stree | | ES 2 NO | 261. LOCATION (Street | and Number or | Rural Route Number | | | | | |
| 28 TE | 4 Homicide 6 Could not be detarmined | building, etc. (Specify) | | | | City or Town, State, | | | | | | | |
| 흳 | 29a. CERTIFIER 1 CERTIFYING PHYSICIA | N: To the best of my knowledge, o | death occurred at | the time, data | and place, and due | to the cause(a) and ma | nner ag stated. | | | | | | |
| ANT: If ite | One) 2 MEDICAL EXAMINER: (| On the basis of axamination and/o | er Investigation, In | my opinion, de | eath occured at the | time, data and place, ar | nd due to the c | ause(a) and manner as stated. | | | | | |
| MPORTANT: II | 29b. SIGNATURE AND TITLE DF CERTIFIER | Q | 1061 | -) | 29c. LICENSE NU | MBER 707 | 29d. DATE S | IGNED (Month, Day, Year) | | | | | |
| 10 | JOHN ADDO, M. D. | DMPLETED CAUSE OF DEATH (V | <u> </u> | | +- | 0/23 | - | 84 | | | | | |
| | JOHN ADDO, M.D. | | | | - 5601 L | OCH RAVEX | BUND | BAUTIMORE 21239. | | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE | | | | | | ~1077 | | | | | |
| | SEP 0 7 1994 | Juli Danison- | Ruce | | | | | | | | | | |



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The personners that the death certificate be executed within Cours after death. Page 6 may be retained by the brospital or attending physician.

TO THE FUNERAL DIRECTOR After this certifician has been somed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with it is say, con or hearth and Mental Hygiene prior to burial, cremation, or removal.

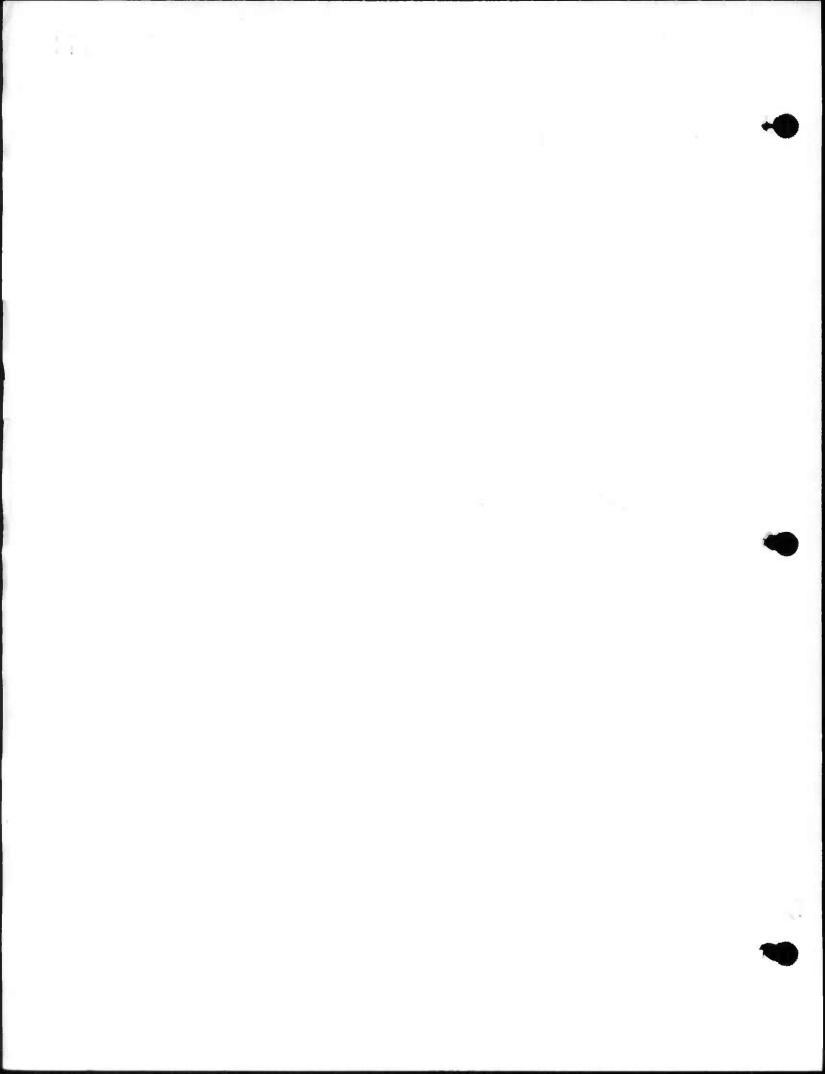
| FOR STATE REGISTRAR | STATE OF | | | OF HEALTH AND OF DEATH | MENTAL HYGIENI REG. NO. |
|--|----------|----------|----------|------------------------|----------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last) | a.k.a. | Florence | Virginia | 01iver | 2. DATE OF DEATH |

| | HEGISTHAR | | CERT | IFICALE | OF DEATH | REG | NO. | | | |
|---|--|------------------------------|-------------------------------|--------------------------------------|--|--|-----------------|---|--|--|
| ľ | 1. DECEDENT'S NAME (First, Middle, Last) | a.k.a. Flor | | | | 2. DATE OF DEA | | 3. TIME OF DEATH | | |
| | Virginia | F. | | eredith | <u> </u> | Sept. | 5, | 1994 8:43 A M | | |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. lest birthdi | Month Day Yes | | | | BIRTHPLACE (State or Foreign Country) | | |
| | 218-03-9692 | 1 🗆 M 2 💢 F 7 | 9 YR | 3. MONTHS | ATS HOURS MIN. | March 1 | 5, 191. | Maryland | | |
| _ | 9a, FACILITY NAME (If not institution, give : | street and number) | | 9b. CITY, TO | OWN OR LOCATION OF D | EATH | 9c. COL | UNTY OF DEATH | | |
| P. | Good Samaritan | Hospital | | P | altimore (| City | | | | |
| 딦 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | Υ | 100 | CITY, TOWN OR | OCATION | | | | | |
| DIRECTOR | Maryland | | | altimo | | | | 10d. INSIDE CITY LIMITS? | | |
| 1 | 10e. STREET AND NUMBER | | E | altimor | 101. ZIP CODE | | 12211.00 | 1 X YES 2 NO | | |
| FUNERAL | 4508 White Avenu | | | | 21206 | | | TIZEN OF WHAT COUNTRY? | | |
| N N | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | IN HO ABMED | T 40 110 | | uu uu uu uu uu uu uu uu uu uu uu uu uu | | S.A. | | |
| | 1 Never Married 2 X Married | FORCES? 1 YES | 2 X NO | If y | DECENDENT OF HISPA in, specify Cuban, Maxic | an, Puarto Rican, at- | ly Yes or No— | 14. RACE — American Indian, Black, White, atc. | | |
| B | 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR I | DATES | 1 1 | YES 2 NO Specif | fy: | | Specify: White | | |
| | 15. DECEDENT'S EDU | CATION | 16a. DECEDEN | T'S USUAL OCCU | PATION | 16b, KIND O | F BUSINESS/IN | | | |
| <u> </u> | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 +) | (Give kind life. Do NO | of work done duri T use retired.) | ng most of working | | | | | |
| 그를 | | N/A | Homen | aker | | Own | Home | | | |
| ON COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | • | | 16. MOTHER'S NA | AME (First, Middle, M | siden Sumame) | | | |
| E E | Henry Oliver | | | | France | es V. Man | tin | | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAIL | ING ADDRESS (S | treet and Number or Rural | | | (ip Code) | | |
| examiner must be notified at once. TO BE COM | Gary A. Meredith | | 4508 | White | Avenue, Ba | altimore, | Md. | 21206 | | |
| 2 | 20a METHOD OF DISPOSITION 1 ABurier 2 Cremation 3 Rem | ovel from State | b. PLACE AND DA | | N (Name of | DATE 20 | c. LOCATION — | - City or Town, State | | |
| E | 4 Donetion 5 D Other (Miscry) | | metery, cremetory Cedar Hi | .11 Ceme | tery | 9/9 | Glen Bu | rnie, Maryland | | |
| | 21. SIGNATURE OF FUNDINAL SERVICE LIC | CENSEE | | | ME AND ADDRESS OF FA | | | | | |
| exa | 1//nin 2 | Zaine | | | | . W1 01010 | | | | |
| | | complications that cause | d the death. D | o not enter the | OT DIGITIES | has cardiac or | T L TIHOT | reat, Approximate | | |
| ше шевіся | 23. ART I. Enter the disease, or ahock, or hear failure. | List only one cause on | each line. | | / | | capitatory at | interval Between Onset and Death | | |
| Ê | MMEDIATE CAUSE (Final disease or condition | MIDROX | della | 111 6 | Mart | | | | | |
| JE J | resulting in death) | DUE TO (OR AS | A CONSEQUENCE | OF) | W | | | | | |
| any injury, or other traumatic event, | | COPP | | 0 | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS | A CONSEQUENCE | OF): | | | | | | |
| 8 8 | cause. Enter UNDERLYING CAUSE (Disease or injury | C- | | | | | | | | |
| | that initiated events | DUE TO (OR AS | A CONSEQUENCE | OF): | | | ** | | | |
| 5 H | resulting in death) LAST | d | | | | | | | | |
| | PART II. Other significant condition | na céntributing to death i | but not resultin | o in the unde | dylag cause given in | Dort I or un | S AN AUTOPSY | | | |
| EDICAL | 08.212 | VII a | out not resulti | g in the ande | lying cause given in | | REORMED3 | AVAILABLE PRIOR TO | | |
| ED | - IZCVIAVO | 31.00 | | | | 1 🗆 YI | S 2 NO | OF DEATH? | | |
| 3 | DID TODA CCO LICE CONT | | | | | | / \ | 1 TYES 2 NO | | |
| 74 | DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL | KIBUTE TO CAUSE C | 26. PLACE OF D | | | ИЦ | | / / | | |
| 1 | EXAMINER? | HOSPITAL: | | OTHER: | | | | | | |
| PHY | 27. MANNER OF DEATH | 1 Inpatient 2 ER/Out | patient 3 DO/ | | Home 5 Residence | 8 Other (Specify 28d, DESCRIBE H | | 201050 | | |
| ВУ РР | 1 Natural 5 Pending | (Month, Day, Year) | 1000 | INJURY | WORK? | 200. DESCRIBE N | OW INJURY OC | COMED | | |
| | 2 Accident Investigation 3 Suicide B Could not be | 28a. PLACE DF INJUR | Y — At home, far | | | 281 LOCATION (S | met and Numbe | er or Rural Route Number. | | |
| TED | 4 Homicide 8 Could not be | building, atc. (Spe | cify) | , | | City or Town, | | or rural riodio rumbal, | | |
| | 29a. CERTIFIER | | 54 V 547 V | N-1-2- T | | Serial Control | | | | |
| MP | (Check only | CIAN: To the best of my know | | | | | | | | |
| BE COMPLE | | | on and/or investig | ition, in my opini | on, death occured at the | time, data and plac | a, and due to 1 | tha cauee(a) and mannar as stated. | | |
| BE | 29b. SIGNATURE AND THE OF CERTIFIES | m | | | 29c. LICENSE NUI | MBER | 29d, DAT | TE SIGNED (MANIN, Day 1944) | | |
| 2 | [mu | 1111 | | | 1152 | 721 | | 9/0/04 | | |
| 1 | 30. NAME AND ADDRESS OF PERSON WH | | | | Ba1 | timore, | Md. 21 | 204 | | |
| | Dr. Richard G. D | | | nal Bld | g., 7401 0 | sler Dr. | Suite | 201, | | |
| | | 32. REGISTRAR'S SIGN | | | | | | | | |
| 1 44 | SEP 0 7 1994 | Their Danden-1 | | | | | | | | |

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| 1 | ING PASS | Utar Mile d | eattherthi | mark d. |
| 1 | ENDING PASS | R. Affar Mis q | or deathwrith | is marked. |
| 1 | STENDING PASS | CTUR: After Mis of | after deathwith | 28 is marked. |
| 1 | OR ATTENDING PACS | DIRECTOR: After Mis of | hours after deathwriths | item 28 is marked. |
| 1 | TAL OR ATTENDING PARSI | TALL DIRECTOR: After NIE of | 72 hours after deathwrith | If them 28 is marked. |
| 1 | SCHITAL OR ATTENDING PARSI | INERAL DIRECTOR: After His of | thin 72 hours after death with | JAT: If Item 28 is marked, |
| | E HOSPITAL OR ATTENDING PASSI | E FUNERAL DIRECTOR: After MIS O | 1 within 72 hours after death with | RTANT: If Item 28 is marked, |
| | O THE HOSPITAL OR ATTENDING PASICIANI THE LIM INquires that the death certificate be ex | O THE FUNERAL DIRECTOR. And the greatest has been signed by the attending physician a | filed within 72 hours after death with | MPORTANT, II item 28 is marked, or item 23 shows any injury, or other traum: |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTA CERTIFIC | | | MENTAL HYGIEN REG. NO. | | | | |
|---------------|---|---|---|---------------------------|--------------------------------|--|---------------|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last, HFLEN) | M. MANA | ING | | | 2. DATE OF DEATH | AY YE | 3. TIME OF DEATH | | |
| | 4. SOCIAL SECURITY NUMBER 7578 | 5. SEX 6. AGE | , | UNDER 1 YEAR NTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | BIRTHPLACE (State or Foreign Country) | | |
| _ | 9a. FACILITY NAME (If not institution, give | | 1 | . CITY, TOWN OF | R LOCATION OF DE | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT | atric Cente | | | | | 1/2/- | HIMORE | | |
| JIRE | Maryland | ΓY | | own or location timore | ON | | | 10d. INSIDE CITY LIMITS? 1 1 VES 2 □ NO | | |
| | 10e. STREET AND NUMBER | | Dai | ZIP CODE | 1.8 | | | | | |
| FUNERAL | 136 S. Potomac S | treet | IC ORIGIN? (Specify Yes | U.S.A | RACE — American Indian. | | | | | |
| BY FU | 1 Never Married 2 Married 3 X Widowed 4 Divorced | FORCES? 1 YES | 2 X NO | If yes, spec | | n, Puerto Ricen, elc.) | 10,100 | Black, White, alc. Specify: | | |
| | 15. DECEDENT'S ED | UCATION | 18a. DECEDENT'S US | UAL OCCUPATION | N . | 18b. KIND OF BU | SINESS/INDUST | White | | |
| COMPLETED | (Specify only highest grad Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of work life. Do NOT use re | · · | t of working | | | | | |
| OMP | N/A 17. FATHER'S NAME (First, Middle, Last) | N/A | Saleslady | 7 | 18. MOTHER'S NA | Clothi WE (First, Middle, Malden | ng Sto | ore | | |
| BE C | Peter Mech | | utz | | | | | | | |
| 10 | 190, INFORMANT'S NAME (Type/Print) Thomas A. Manning | g (Son) | | | | Baldwin, M Baldwin, M | | de) .013 | | |
| | 20e METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Re | | b. PLACE OF OISPOSITE other place) | | | | | or Town, Slate | | |
| | 4 Donallon 5 Other (Specify) | Ga | ardens of | | emetery | | ltimor | e, Maryland | | |
| | → // - | 7 11 | | Schin | nunek Fu | neral Home | | W1 01010 | | |
| | 23. PART I. Enter the diseases, or | | | _ | | Lane, Balt | | , Approximate | | |
| | IMMEDIATE CAUSE (Final disease or condition | . List only one cause on a | ach line. | . 1 1 | | | | Interval Batween Onset and Dasth | | |
| | reaulting in death) | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | Thou | | |
| N | Sequentially list conditions, | . Demote | i. Some | lity | | | | >37 | | |
| CERTIFICATION | If any, leading to immediate csuse. Enter UNDERLYING | DUE TO (OR AS A | A CONSEQUENCE OF): | , | | | | | | |
| TIF | CAUSE (Disease or Injury that Initiated avents resulting in death) LAST | OUE TO (OR AS | CONSEQUENCE OF): | | | | | | | |
| | DART II Oh a shadhasa asa dhi | d. | | | | | | I | | |
| CAL | PART II. Other significant condition | ms contributing to death i | out not resulting in 1 | ina undariying | cause given in | Part I. 24e. WAS AN PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE | | |
| MEDIC | .2 | | | | | | | OF DEATH? | | |
| AN: | 25. WAS CASE REFERRED TO MEDICAL | 1 | | 26 01/ | ACE OF DEATH (Ch | nok only one) | | | | |
| PHYSICIAN: | EXAMINER? 1 YES 2 NO | HOSPITAL: | | THER: | | 8 Other (Specify) | | | | |
| PHY | 27. MANNER OF DEATH 1 Natural 5 Pending | 28s. DATE OF INJURY (Month, Day, Year) | 28b. TIME C | Y WOF | RK? | 28d. DESCRIBE HOW | INJURY OCCUR | RED | | |
| ВУ | 2 Accident Investigation 3 Suicide s Could not b | 28a. PLACE OF INJUR | Y — At home, farm, stre | | ES 2 NO | 281. LOCATION (Street | | Rural Route Number, | | |
| ETEC | 4 Homicide determined | building, etc. (Spe | icity) | | | City or Town, State | | | | |
| COMPLETED | CONSCR ONLY | SICIAN: To the best of my know | | | | | | ause(a) and menner ea stated. | | |
| BE C | 29b. SIGNATURE AND TITLE OF CERTIF | ER | | | 29c. LICENSE NUI | | 29d, DATE S | IONEO (Month, Day, Year) | | |
| TO E | 30. NAME AND ADDRESS OF PERSON V | VHO COMPLETEO CAUSE OF O | EATH (ITEM 27) (Type, Pr | int) | עוץ | 221 | | 1.6.19 | | |
| | Dr. Tarique Fir | ozvi, 223 Eas | tern Blvd | | more,Md. | 21221 | | | | |
| | 31. DATS EEP MOUNT PO1994 | 32. REGISTRAR'S SIGI | NATURE | 100 | | | | | | |



3. TIME OF DEATH

10d. INSIDE CITY LIMITS? 1 YES 2 NO

Approximate Interval Between Onset and Death

24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 TES 2 NO

29d. DATE SIGNED (Month, Day, Year)

14. RACE — American Indian, Black, White, atc.

SpecifyWHITE

8. BIRTHPLACE (State or Foreign Country)

10g. CITIZEN OF WHAT COUNTRY? USA

tarford

1:300 m

94

1 - STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

arry

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| hours |
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| executed |
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| certificate |
| death |
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| | 314-34-7438 | SER | 5. SEX | 6. AGE (In yr | s. last birthday) | MONTHS | DAYS | HOURS | MIN. | 7. DATE OF (Month, D | BIRTH Day: Year) | | 8. BIRTH Countr | IPLACE (State ry) | |
|----------|---|----------------------------|---|----------------|--|---------------|---------------------|---|-----------------------|-------------------------|---------------------|---|--|----------------------|--|
| | 314-34-7436 | | 1 M 2 F | ۲ | YRS. | | 54.0 | liodito | | NOV. | | 936 | | iana | |
| ~ | 9a. FACILITY NAME (If not in | stitution_give s | treet and number) | | 111 | 96. CITY | TOWN C | RILOCATI | ON OF DE | ATH | | 9c. COU | INTY OF D | EATH | |
| 70 | RESIDENCE OF DEC | 1 <u> </u> | neval | TOS | ital | <u> </u> | 9 | 1121 | 100 | | | <u> </u> | tar | tova | |
| DIRECTOR | 10a, STATE | 10b. COUNT | Υ | | 10c. CITY, TOWN OR LOCATION | | | | | | 10d. INSIDE | | | | |
| PHO | MARYLAND | HAR | FORD | | | | | | | LIM 1 YE | | | | | |
| AL | 10a. STREET AND NUMBER | | | | | | 101 | . ZIP COD | E | | | 10g. CIT | IZEN OF V | WHAT COUNT | |
| FUNERAL | 1621 BELAIR | ROAD | | | | | | 21 | 047 | | USA | | | A | |
| | 11. MARITAL STATUS 1 Never Married 2 K | Mandad | | | | | | DECENDENT OF HISPANIC ORIGIN? (Specify Yos, specify Cuban, Maxican, Puerto Rican, etc.) | | | | | Yea or No — 14. RACE — Americ Black, White, a | | |
| R | 3 Wildowed 4 Dive | | | | | | | | Specify | | .,, | | | WHITE | |
| ED | 15. DEC | EDENT'S EDU | CATION | 184 | . DECEDENT'S | USUAL O | CCUPATIO | ON | | 16b. KI | NO OF BUS | SINESS/INI | DUSTRY | | |
| COMPLET | Elementary/Secondary (0 | y highest grade 0-12) | work done se retired.) | | SI of Workii | ng | | | | | | | | | |
| Σ | 12 | | | | | CHI | EF. | | | | | MARI | NE | | |
| ပ္ပ | 17. FATHER'S NAME (First, Middle, Leat) MERLE NEWKIRK MARGARET | | | | | | | | | | dle, Meiden | Surname) | NEW | M A M | |
| BE | 19a. INFORMANT'S NAME (1 | Serve (Obvior) | | | - | | | L | | | | _ | | .16714 | |
| 5 | JOYCE C. NI | | | | 1621 | BELA: | s (Street a IR R | OAD : | r or Rural F FALL: | STON, | MD. | n, State, Zij 2104 | 7 Code) | | |
| | 20a. METHOD OF DISPOSIT | | Λ | 20b. PL | ACE AND DATE | OF DISPOS | ITION (Ne | me of | | DATE | 20c. LO | CATION — | City or To | wen State | |
| | 1 Burial 2 Crematic | | oval from State | cemeler | y, cremetory or c E HILL | ther place) | | | 9 | /9/94 | | CATION — City or Town, Stata ILTON, OHIO | | | |
| | 21. SIGNATURE OF THEBA | BENVICE NO | ENTRE / | | | 22. | NAME AN | | SS OF FA | YTIJK | | | | | |
| | 1 C-31 | 17) | KKA | 27 | | - 1 | | | | UNERAI | | | | 4 | |
| | 23. PART i. Enter the diseases or complication that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. | | | | | | | | | | | | | | |
| | IMMEDIATE CAUSE (Fir | aart ranure. | List only one ceu | ise on each | lina. | | | | 0 | | | | | Intan Onsa | |
| | disease or condition resulting in death) | + | a(` | auc | Wholly | lul | ana | 11 | W | lest | | | | n | |
| | | | QUE TO | (OR AS A CO | NSEQUENCE O | 9: Na. / 1 | , , | 2 | | . 1 | | 10. | | h | |
| CALICIA | Sequentially list condit | ions, | * XO | WY CO | - HY | rusi | 0 | | Up | noul | NIO | ros | | 110 | |
| 2 | if any, leading to imme cause. Enter UNDERLY! | | 71 | aid | NSEQUENCE O | ALL | 11/ | 1 | 1 | | | 0 | | 184 | |
| | CAUSE (Disease or Injuthat Initiated avanta | iry 🥤 | DUE TO | (OR AS A CO | NSEQUENCE O | F): | V, | | | 1 1 | 1 | - | \ | 1 | |
| CERILL | that Initiated avanta resulting in death) LAST | | | | | | | | | | |) h | | | |
| - 14 | PART II. Other algolitica | nt condition | na contributing to | daeth but r | ut not resulting in the underlying cause | | | | | Part I | M. WAS AN | AUTOPSY | 740 | . WERE AUTO | |
| EDICAL | AS | CUD |) | | ut not resulting in the underlying cause | | | | | | PERFOR | MED? | 1 | AVAILABLE F | |
| MED | | | | | : : : : : : : : : : : : : : : : : : : | | | | | _ * | ☐ YES 2 | South | | OF DEATH? | |
| AN: | DID TOBACCO | O USE | CONTRIBUTE | TO CA | AUSE OF | DEAT | ГН Ү | ES 🖂 | NO | | | | | 11,000 D.T. | |
| S | 25. WAS CASE REFERRED TO EXAMINER? | O MEDICAL | HQSPITAL: | | | 071 | | ACE OF D | EATH (Che | ck only one) | | | | | |
| 1 | 1 TYES 2 THO | | Inpatient 2 | | nt 3 🗆 DOA | 4 Nun | | • 5 □ Ra | aldenca | 6 Other (S | Specify) | | | | |
| FILLS | 27. MANNER OF DEATH | Pending | 26a. DATE OF (Month, D | | 26b. TIN | IE OF JURY | | RK? | - 202 | 28d. DESCR | IBE HOW I | NJURY OC | CURED | | |
| ā | 2 Accident | Investigation | 26a, PLACE O | F INJURY — | At home, lerm, | etraat Inci | | /ES 2 | NO | 201 1 0001 | ON (Change of | | | D | |
| 9 | | Could not be detarmined | building, | etc. (Specify) | At Home, term, | atteut, ract | ory, orner | | | | lown, State) | ind Number | or Hurai F | Route Number | |
| 4 | 29a, CENTIFIEN , CENT | IEVING BHYEI | CIAN: To the heat of | mu ba auda da | . d. ob | | | | 73.1 | G | | | | | |
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| 6 | M | ~ | = 1 X N | | Lus | | | 6 | 77 | 7000 | | ZYG, UAT | 3 C | (Month, Day, | |
| 2 | 30. NAME AND ADDRESS OF | F PERSON WH | O COMPLETED CAUS | SE OF DEATH | (ITEM 27) (Type | | | | 00 | | - | | 5.00 | 1 | |
| | BARRY | 11/1 | JI MI |) . | 658 | PM | VIII | ZI A E | 2 | () | 161 | 2 13 | SULC | my | |

32. REGISTRAR'S SIGNATURE i Sintem-Rendall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

2. DATE OF DEATH

DHMH-16 Rev 1/89



31. DATE FILED (Month, Day, Year) SEP 0 7 1994

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| COMPANIENCE PHYSICIAN: The law requires that the death certificate be executed within Flours | |
| | quarter Now PHISICIAN: The law requires that the death certificate be executed within cours after death. Page 6 may be retained by the hospital or attending physici |

TO THE HOSPITL OF TO THE FLINEFILL OF be filed within 7 co.

RECORD After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be a marked, be the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. ttending physician. CHARLENDING PHISICIAN: The law requires that the death cert

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | HEGISTHAH | | 0. | | ICAIL | . 01 | DLA | | | REG. NO. | | | |
|------------------------------|--|--|--|--|--|---|--|---|--|--|--|---------------------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF MONTH | DEATH DA | W | YEAR | 3. TIME OF DEATN |
| | GEORGE A. NEUME | | | | 10000 | | | | | EMBE | R 5. | | |
| | | 5. SEX 1 ☑ M 2 ☐ F | 8. AGE (In yrs. les | t birthday) | IF UNDER | DAYS | HOURS | BARNA | 7. DATE OF (Month, L | lav, Year) | | Countr | |
| | 216-20-8034 9a. FACILITY NAME (If not Institution, give str | | 85 | NO | | | | | | | | IMORE, MD | |
| œ | CHARLESTOWN CAR | | | | 96. CITY, TOWN OR LOCATION OF DEAT CATONSVILLE | | | | EATH | | 9c. COU | | |
| 유 | RESIDENCE OF DECEDENT | E CENTER | | | | AIU | MPATI | LLE | | | L | BAI | LTIMORE |
| DIRECTOR | 10e. STATE 10b. COUNTY | | | 10c. CIT | , TOWN O | R LOCAT | ION | | | | 10d. INSIDE CITY | | |
| | MARYLAND | BALTIMO | RE | CATONSVILLE | | | | | | | | | 1 YES 2 NO |
| ¥ | 10e. STREET AND NUMBER | | | | | 101 | . ZIP COD | E | - | | 10g. CIT | IZEN OF V | VNAT COUNTRY? |
| FUNERAL | 701 MAIDEN CHOICE | LANE | | | | | 2122 | 8 | | | U.S | .A. | |
| 2 | 11. MARITAL STATUS 1 Never Married 2 Merried | EVER IN U.S. AR | MED | 13. V | WAS DEC | ENDENT C | F HISPAN | IIC ORIGIN? (| Specify Yee | or No- | 14. RACE | - American Indian, c. White, etc. | |
| ВУ | 3 Widowed 4 Divorced | AR OR DATES | | | | 2 X NO | | | ,, | | Speci | ,, | |
| | 15. DECEDENT'S EDUC | 16a, DF | CEDENT'S | USUAL OC | CUPATIO | N. | | 185 M | ND OF BUS | INECC/INI | DISTRY | WILLE | |
| | (Specify only highest grade of Elementary/Secondary (0-12) | completed) College (1-4 or 5+) | (Gi | | vork done d | | | ng | 100. K | ND OF BOO | MESSAMI | DOSINI | |
| 립 | | 5 YRS | | EACH | ΞR | | | | HIC | GH SC | HOOL | | |
| COMPLETED | 17. FATNER'S NAME (First, Middle, Last) | | | | | 18. MOTI | NER'S NA | ME (First, Mid | | | | | |
| BE C | GEORGE A. NEUMEIST | | | | | BAR | BARA | KARMA | AN | | | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | 198 | . MAILING | ADDRESS | (Street a | nd Number | or Rural F | Route Number, | City or Town | n, State, Zij | p Code) | | |
| F | GEORGE J. NEUMEIST | 2 | 16 C | DRNET | - 1 | LINT | HICU | M,MD | . 2 | 1090 | | | |
| | 20e. METHOD OF DISPOSITION 1 (X) Burlel 2 Cremellon 3 Remove | 20b. PLACE A cemetery, crea | ND DATE | F DISPOSI | TION (Na | me of | | DATE | 20c. LO | CATION - | City or To | wn, Stata | |
| | 4 Donation 5 Other (Specify) | | DULANE | Y VA | LEY | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | INSEE | | | 22. N HUI | BBAR | D ADDRES | NER A | CILITY LL HOM | F IN | IC. | | |
| | D hans Ci | 1 Softer | Minson |) | 410 | 07 W | ILKE | NS A | VENUE | -RΔT.T | TIMORE, MD. 21229 | | |
| | 23. PART i. Enter the diseases, or co | omplicationa that | caused tha de | ath. Do r | ot antar | the mo | de of dyl | ing, suci | h as cardia | or respi | ratory an | rest, | Approximata |
| | shock, or heart failure. L IMMEDIATE CAUSE (Final | let only one caus | e on asch lina | na. | | | | | | | | Interval Between Onset and Death | |
| | disease or condition | | BLEED FROM URETI | | | | | | | | | | |
| | resulting in death) | LICE | 150 | - EE | 0 | FR | -our | () RE | TIVA | A | | 3 DAYS | |
| | resulting in death) | | OR AS A CONSEC | | | 0 | FR | Low | ORE | THA | A | | 3 DA45 |
| NO | Sequentially fist conditions. | DUE TO (| OR AS A CONSEC | DUENCE OF |): | 0 | FR | Lon | ORE | TIVA | . A | | 30945 |
| ATION | Sequentially list conditions, if any, leading to immediate | DUE TO (| | DUENCE OF |): | D | FR | Lom | ORE | ETHA | A | | 3 DA45 |
| FICATION | Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury | DUE TO (| OR AS A CONSEC | DUENCE OF | j: j: | 0 | FR | -011 | ORE | ETHA | . A | | 3 DA45 |
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1 | . D | | ME (First, Middle, Last) | | | | - |
|---|-----|---------------------------|--------------------------|--------|----|-----|---|
| 1 | - | FOR STATE REGISTRAR | | STATE | 0F | MAR | Y |
| | | Item 1, | g-/10,9-/-9 | 4, per | n. | Пед | U |

| 1 - STATE REGISTRAR | | STATE OF I | MARYLAND / Ci | | | NT OF H | | | MENTA | REG. NO. | E | | |
|---|--|---------------------------------------|--------------------------------------|--------------|------------|---|------------------------------------|---------------------------------|---------|-------------------------------------|---------------|--------------------------------------|--|
| 1. DECEDENT'S NAME (First MINOLA Di | , Middle, Last) ckens A. | K.A. Weath | erby/Weat | hers | /NA | NCE | | | MON | | | YEAR | 3. TIME OF DEATH |
| 4. SOCIAL SECURITY NUM | | 5. SEX | 6. AGE (In yrs. les | | | DER 1 YEAR | IF UNDER | 24 HRS. | 7. DATE | EPT 05 | | | 7:40 AM PLACE (State or Foreign |
| 215-30-86 | 24 | 1 🗆 M 2 🖎 🏋 F | 59 | YRS. | MONTH | B DAYS | HOURS MIN. J MONTA 207. 1935 MARRY | | | | | YLAND | |
| 9e. FACILITY NAME (If not in | nstitution, give st | reet and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | EATH |
| 2115 MURA | STRE | ET | | | В | BALTI | MOR | E | | | | n/a | |
| MARYLAND | 10b. COUNTY | n/a | | 10c. CIT | Y, TOWN | ALTI | MORE | | | | | 10d. INSIDE CITY VLIMITS? 1 YES 2 NO | |
| 100. STREET AND NUMBER 2115 | | | 10f. | 21 2 | 13 | | | 189. CIT | E D | STATES | | | |
| 11. MARITAL STATUS 1 Never Married 2 3 3 Widowed 4 Divo | IT EVER IN U.S. AR YES 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | MED NO | 1: | | cify, Cube | n, Mexice | n, Puerlo | N? (Specify Yes Rican, etc.) | or No- | Black | , White, etc. | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use relired.) 16. KIND OF BUSINESS/INDUSTRY 16. KIND OF BUSINESS/INDUSTRY 16. KIND OF BUSINESS/INDUSTRY 16. KIND OF BUSINESS/INDUSTRY 16. KIND OF BUSINESS/INDUSTRY 16. KIND OF BUSINESS/INDUSTRY 16. KIND OF BUSINESS/INDUSTRY | | | | | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Lest) THEODORE WAETHERBEE 16. MOTHER'S NAME (First, Middle, Meiden Surneme) HENRIETTA JACOBS | | | | | | | | | | | | | |
| 190. INFORMANT'S NAME (1 | | EATHERE | | 3602 | | SS (Street or | | | | UE, B | | | E, MD#15 |
| 29a. METHOD OF DISPOSIT 1 Buriel 2 Crematic 4 Donation 5 Other | | val from State | 20b. PLACE | | | | | 1ETE | RY | | | City or To | un, State LLE, MD |
| 21. SIGNATURE OF FUNERA | L SERVICE LIC | ENSEE | 0 | | | 2. NAME AN | | | | | - 1 | | |
| del | 11: | Holla | mo | | | | | | | | | | ORTH AVE. |
| | aart fallure. L | omplications the list only one car | it caused the de use on each line | ath. Do r | not ente | er the mod | de of dyl | ng, auch | as cer | diac or respi | ratory an | est, | Approximate Interval Between |
| IMMEDIATE CAUSE (Fir disease or condition resulting in death) | → a | Arte | OR AS A CONSE | tic OUENCE O | F): | erdia | vosa | la | 6 | men | | | Onset and Death |
| Sequentially list condit if any, leading to imme- cause. Enter UNDERLY! CAUSE (Disease or inju- that initiated eventa resulting in death) LAS | diate ING Iry | | (OR AS A CONSEC | | | | | | | | - | | |
| PART ii. Other algnifica | nt conditions | contributing to | death but not r | eaulting | in the i | underlying | cause g | iven in | Part i. | 24a. WAS AN | | 24b. | WERE AUTOPSY FINDING9 |
| | | | | | _ | | | | _ | PERFOR | 10 | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| DID TOBACCO U | SE CONTR | IBUTE TO CA | USE OF DEA | TH YE | s 🗆 | NO 🗆 | UNC | ERTAIN | 1 🗆 | Mispe | cton | | 1 120 2 110 |
| 25. WAS CASE REFERRED TO EXAMINER? | O MEDICAL | HOSPITAL: | | E DF DEA | OTHE | ER: | 1.55 | | | | | | |
| 1 VES 2 NO 27. MANNER OF DEATH | | 1 Inpetient 2 | INJURY | 26b. TIM | E OF | 28c. INJU | RY AT | sidence | | er (Specify) SCRIBE HOW IN | JURY OC | CURED | |
| | Pending Investigation | (Month, E | esy, 19ar) | INJ | M | t 🗆 Y | | NO | | • | | | |
| | Could not be determined | 26e. PLACE C building. | F INJURY — AI ho atc. (Specify) | me, farm, : | atroot, te | ectory, office | | | | CATION (Street a or Town, Stete) | nd Number | or Rural R | oute Number, |
| | | CIAN: To the best of | | | | | | | | | | | end menner se stated. |
| 29b. SIGNATURE AND TITLE | | . On the besis of e | Administration end/or i | investigatio | in, in my | opinion, de | | NSE NUM | | e end place, end | | | Committee of the commit |
| 30. NAME AND ADDRESS OF | LE M | COMPLETED CO. | SE OF DEATH (ITE | D. | Drings | | | C.M | | | | | (Morth, Day, Year)) 5 , 1994 |
| THEODER | UE / | UKEN | | | | Stree | et, | Bal | tim | ore, M | Mary | land | 1 21201 |
| SEP | 7 199 | 4 32. REGISTA | R'9 SIGNATURE | Manufa | M | | | | | | | | |

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BALTIMORE, MARYLAND 21215-0020

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| DIMISION OF VITAL RECORDS, P.O. BOX 68 | TO THE HIGGING OF ATTENNING PHYSICIAN: The law requires that the death certificate be execu | TO THE FUNE WHEN THE THE PARTY IN SERVICE TO THE SIGNED BY THE attending physician and | 2 | IMPORTANT New 21 marked, or Item 23 shows any Injury, or other traumati |
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29b. SIGNATURE AND TITLE OF CERTIFIER

Mustafa Abbasi MD

'SEP 0 7 1994

Assan M.D.

32. REGISTRAR'S SIGNATURE

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

| IAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | re this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page at the Wental Hygiene prior to burial, cremation, or removal. | shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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| The law | te has I | эт 23 |
| IAN: T | rificate le Stat | or ite |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH 1994 NOOFT Julia September 6 11:20 Рм 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTN 8. BIRTNPLACE (State or Foreign IF UNDER 1 YEAR | IF UNDER 24 HRS. June 9. 83 Maryland DAYS HOURS 1 M 2 KF MIN. 1911 YRS. 214 30 5970 Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF OFATH Franklin Sq. Hospital DIRECTOR Rossville Baltimore County 10a. STATE Maryland Baltimore 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Essex 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZfP CODE 10g. CITIZEN OF WHAT COUNTRY? 538 21221 USA Back River Neck Rd. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. RACE — American Indian, Black, Whita, alc. FORCES? 1 YES 2 1 Never Married 2 Married BY 1 YES 2 NO Specify Specify: White 3 Wildowed 4 Divorced COMPLETED 15. DECEOENT'S EDUCATION 18a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) Home Housewife 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Unknown Unknown BE 19s, INFORMANT'S NAME (Type/Print) 19b. MAILINO AODRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2 Henry Nooft, Son 538 Back River Neck Rd. Baltimore, MD 21221 20a. METNOO OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE 1 Specific 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Company Hill Memorial Gardens 9/9/94 Baltimore Co., MD 21. SIGNATURE OF UNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF EACHLITY
Druzdzinski Funeral Home PA 1407 Eastern Ave. Baltimore, MD 21221 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximata shock, or heart fallura. List only one cause on each line. Interval Batween IMMEDIATE CAUSE (Final Onset and Daath disease or condition resulting in death) Metabolic Acidosis/ Hyponatremia DUE TO (OR AS A CONSEQUENCE OF): L Questionable Sepsis
OUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequantially list conditions, If any, leading to immediate cause. Enter UNDERLYING Acute Renal Failure CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMEO? MEDICAL Syndrome of inappropriate anti-diuretic hormone 1 YES 2 NO OF DEATH? Osteoarthritis 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) **EXAMINER?** HOSPITAL:
14 Inpatient 2 ER/Outpatient 3 DOA OTHER: 1 | YES 2 1 NO 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF OEATN 28a. OATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED 1 X Natural 5 Pending fnvestigation м 1 YES 2 NO В 2 Accident 28s. PLACE OF INJURY — At home, farm, streel, factory, office building, stc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 8 Could not be 4 Nomicide 29a. CERTIFIER 1 (CERTIFYINO PHYSICIAN: To this best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and manner as attend.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

9000 Franklin Square Drive Baltimore, Maryland

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year)

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GNATURE AND TITLE OF CERTIFIER

MD

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

Rd

32, REGISTRAR'S SIGNATURE

RH WIEDEFELD

PHOGUIX Mel

| THE SECTION OF THE LAW REQUIRES THAT THE GREAT CENTRICATE OF EXECUTED WINN THOURS ATRY DESTINATION OF THE HOSPITAL OF ATTENDING PHYSICIAN. | I this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should | a men death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | n 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATN 3. TIME OF CEATN 1994 5:50 ETHEL LOUISE PARKS 9 a 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 6. BIRTNPLACE (State or Foreign HOURS 1 M 2 XF 25-78-2607 YRS. June 24, 94 1900 Md 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Greater Baltimore Medical Center Towson Baltimore DIRECTO 10b. COUNTY 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Baltimore Cockeysville 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 13501 York Rd. 21030 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: В Specify: 3 Nidowed 4 Divorced White COMPLETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hi Elementary/Secondary (0-12) College (1-4 or 5+) Home maker Own Home 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Calvin D. Price Dora L. Miles BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Peggy M. Miller 211 Quaker Bottom Rd. Sparks, Md. 21152 20e. METHOD OF DISPOSITION
1 M Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE 4 ☐ Donation 5 ☐ Other (Specify) Jessup Methodist Cemetery 9/6/94 Sparks, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home Inc. 1050 York Rd. Towson, Md. 21204 23. PART | Enter the diseases, of complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heert feliure. List only one cause on each line. Approximate interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Acute MYOCAROINE INFANCTION resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initieted eventa resulting in deeth) LAST PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO CHADIO UASCULAR DISGASE 1+11000 SCLGNOTIC COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL:
1 X Inpatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2X NO 4 - Nursing Home 5 - Residence 27. MANNER OF DEATN 28a. DATE OF INJURY 28c. fNJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 K Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, term, street, fectory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) LETED 8 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner ee stated. 2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, data end piece, end due to the cause(e) end menner ee stated.

29c. LICENSE NUMBER

2113

29d. DATE SIGNED (MINISTER)

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| | 1. DECEDENT'S NAME (First, Middle, L | 1. 10021/ | | | 2. DATE OF DEATH MONTH DAY | YEAD | 3. TIME OF DEATH |
|----------------------------|--|--|--|---|--|-----------------------------------|--|
| | 4. SOCIAL SECURITY NUMBER 22/-/4-157 | 0 12 0 F 76 | yrs. last birthday) IF UNDER MONTHS | 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN. | 7. DATE OF BIRTN (Month, Day, Year) 6-8-1918 | Count | NPLACE (State or Form |
| TOR | 90. FACILITY NAME (If not institution, g | ICAL CENTER | | TO CTTY | EATH 9c. 0 | COUNTY OF E | DEATN |
| L DIRECTOR | 10e. STATE 10b. CO | | 10c. CITY, TOWN C | MORE | | | 10d. INSIDE CITY LIMITS? YES 2 \(\square\) N |
| FUNERAL | | NA CIRCLE AP' | | 101. ZIP CODE 21051 MAS DECENDENT OF NISPA | | U.S.A | |
| B | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? TYPES | 2 NO | f yes, specify Cuben, Mexico I YES 2 XNO Specif | in, Puerto Rican, etc.) | | E — American Indiar k, White, atc. JACK |
| PLETED | 15. DECEDENT'S (Specify only highest s | | 16a. DECEDENT'S USUAL O (Give kind of work done life. Do NOT use retired.) | CCUPATION furing most of working | 166. KIND OF BUSINESS | /INDUSTRY | |
| BE COMPL | 17. FATHER'S NAME (First, Middle, Lest | | 11/4 | | ME (First, Middle, Melden Surner NNTE CAREY | ne) | |
| TO B | 190. INFORMANT'S NAME (Type/Print) MARTHA ALEXA | NDER | | | Route Number, City or Town, State | | |
| | 20a. METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 4 Donetion 5 Other (Specify) 21. SIGNATURE OF THE RALL SERVICE | Removal from State Came | PLACEAND DATE OF DISPOS Nery, cremetory of other plecel ROWNSVILL | TION (Name of CEM | DATE 200 LOCATION SUNRI | | eACH RO |
| | 23. PART I. Enter the diseases, ahock, or heart failt iMMEDIATE CAUSE (Finel disease or condition resulting in death) | re. List only one cause on asc | the death. Do not enter ch line. | the mode of dying, aud | | 2 W.1 | Approxima Interval Be Onset and |
| z | | DUE TO (OR AS A O | PERNA CONSEQUENCE OF: YDRAT/ | 010 | // / | | a wa |
| SERTIFICATION | Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A C | YDRATI | 01V | | | a we |
| N: MEDICAL CERTIFICATION | Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A C | VDRA-T/ CONSEQUENCE OF): | 010 | | | AMAILABLE PRIOR T COMPLETION OF CA OF DEATH? |
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| PHYSICIAN: MEDICAL | Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent cond | DUE TO (OR AS A C. DUE TO (OR AS A C. DUE TO (OR AS A C. d. Ribna contributing to death but DUE TO (OR AS A C. DUE TO (O | CONSEQUENCE OF): CONSEQUENCE OF): It not resulting in the under the constant of the constant | 26. PLACE OF DEATN (C)? 1: Ing Home 5 Residence 28c. INJUST AT WORK? 1 YES 2 NO | Part i. 24s. WAS AN AUTOP PERFORMED? 1 YES 2 OCC Peck only one) | 5 | AMAILABLE PRIOR 1 COMPLETION OF CA OF DEATH? |
| ED BY PHYSICIAN: MEDICAL | Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent cond 25. WAS CASE REFERRED TO MEDICAE EXAMINER? 1 YES 2 100 27. MANNER OF DEATH Disease or Injury that initiated events PART II. Other significent cond PA | DUE TO (OR AS A C. DUE TO (OR AS A C. DUE TO (OR AS A C. d. Ribna contributing to death but DUE TO (OR AS A C. DUE TO (O | CONSEQUENCE OF): CONSEQUENCE OF): It not resulting in the under the consequence of the | 26. PLACE OF DEATN (C)? 1: Ing Home 5 Residence 28c. INJUST AT WORK? 1 YES 2 NO | Part i. 24s. WAS AN AUTOP PERFORMED? 1 YES 2 Coneck only one) 8 Other (Specify) | OCCURED | AMALABLE PRIOR I COMPLETION OF CO OF DEATH? |
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| ED BY PHYSICIAN: MEDICAL | Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent cond 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 27. MANNER OF DEATH 1 Action 1 1 1 1 1 1 1 1 1 | DUE TO (OR AS A C. DUE TO (OR AS A C. DUE TO (OR AS A C. d. DUE TO (OR AS A C. d. DUE TO (OR AS A C. d. DUE TO (OR AS A C. DUE TO (OR AS | CONSEQUENCE OF): CONSEQUENCE OF): It not resulting in the under intent 3 DOA 4 DOA 4 DOA 4 DOA 1 DOA | derlying cause given in 26. PLACE OF DEATN (C/ 1: Ing Home 5 Residence 28c. INJURY AT WORK AT Ory, office me, date and place, and due | Part I. 24a. WAS AN AUTOP PERFORMED? 1 YES 2 OTT Seck only one) 8 Other (Specify) 28d. DESCRIBE HOW INJURY City or Town, Stee) to the cause(e) and menner as | OCCURED mber or Rural is stated. | AMALABLE PRIOR T COMPLETION OF CO OF DEATH? 1 YES 2 AMA Route Number, |

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CERTIFICATION

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94 26118 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Alberta 1994 Gloria Palmisano September 11:00 am 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) 7. OATE OF BIRTH IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. (Morth, Day, Year) 01/23/1915 217-74-4167 1 M 2 X F 79 YRS. Pennsylvania 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH Se. COUNTY OF DEATH DIRECTOR 4201 Walther Avenue Baltimore RESIDENCE OF DECEDENT INC. CITY TOWN OR LOCATION 10b. COUNTY tod. INSIDE CITY Maryland Baltimore t X YES 2 NO FUNERAL toe. STREET AND NUMBER 10f. ZIP CODE tog. CITIZEN OF WHAT COUNTRY? 4201 Walther 21214 Avenue United States t2. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 XNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Not4. RACE — American Indian, Black, White, atc. t Never Married 2 Married If yes, specify Cuban, Maxican, Puarto Ricen, etc.) 1 YES 2 X NO Specify. Specify: BY 3 X Widowed 4 Divorcad White COMPLETED 16a. DECEOENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hi Elementary/Secondary (0-12) College (t-4 or 5+) 12 Homemaker t7. FATHER'S NAME (First, Middle, Last) ta. MOTHER'S NAME (First, Middle, Maiden Surname) John Miscavage BE Anna Bokta 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ACCRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Frank S. Palmisano, Jr., M.D. 811 Wellington Road Baltimore, Maryland 21212 20a. METHOD OF DISPOSITION
t X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE Gardens of Faith Cemetery 4 Donation 5 Other (Specify) 9/9/94 Baltimore, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Zavoyna 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. May 27 guggen-5305 Harford Road 21214 Baltimore 23. PART I. Enter the diseases, of complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Intervai Between **Onset and Death** IMMEDIATE CAUSE (Final disease or condition resulting in death) congestive keurt failure DUE TO OR AS A CONSEQUENCE OF DUE TO (OR AS A COMBENIUM OF) Sequentially list conditions, if any, leading to immedista A.S.C.U.D cause. Enter UNDERLYING CAUSE (Disease or Injury TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO diabetes mellitus; COMPLETION OF CAUSE 1 YES 2 100

actic insufficiency TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES DID

OF DEATH? t TYES 2 TNO

25. WAS

| TOBACCO USE | CONTRIBUTE TO CAUSE OF | DEVILL LES NO |
|--------------------------|---|---|
| CASE REFERRED TO MEDICAL | | 26. PLACE OF OEATH (Check only on |
| NES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA | OTHER: 4 - Nursing Home 5 - Residence 6 - Other |

1 🗆 27. MANNER OF CEATH 28a. OATE OF INJURY t Returni 5 Pending 2 Accident Investigation

8 Could not ba

м t YES 2 NO 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

| 81. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|--|
|--|

(Specify)

28d. DESCRIBE HOW INJURY OCCURED

| ENTIFIER | E CERTIEVING PHYSICIAN. | To the best of my knowledge, dasth | | | - 1 | commence of the control of the contr | |
|------------|-------------------------|------------------------------------|-----------------------|-------------|--------------------|--|--------------|
| check only | CENTIF THE PHYSICIAN. | to the beat of my knowledge, death | occurred at the time, | dat Pend He | ca, and due to the | cause(a) and mann | or as stated |
| 10) | 2 HEDICAL EXAMINED. O. | the best of the state of the | | | | | |

| 2 MEDICAL EXAMINEN. On the basis of a | examination and/or investigation, in my of | pinion, dean occured at the time, data and pi | place, and due to the cause(a) and manner as stated. |
|---------------------------------------|--|---|--|
| E AND THE OF CERTIFIER | _ | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |

28c. INJURY AT WORK?

| ٠ | | almisano fr uns | P -6-94. |
|---|-----------------------------------|--------------------------|--------------------|
| | | MISANO, JR, MID. | d. BALTO MD.2/2/14 |
| ı | 3t, OATE FILEO (Month, Day, Year) | 32 REGISTRAD'S SIGNATURE | |

SET U / 1994

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Mark S. Tarak and Later Land Commence of the C

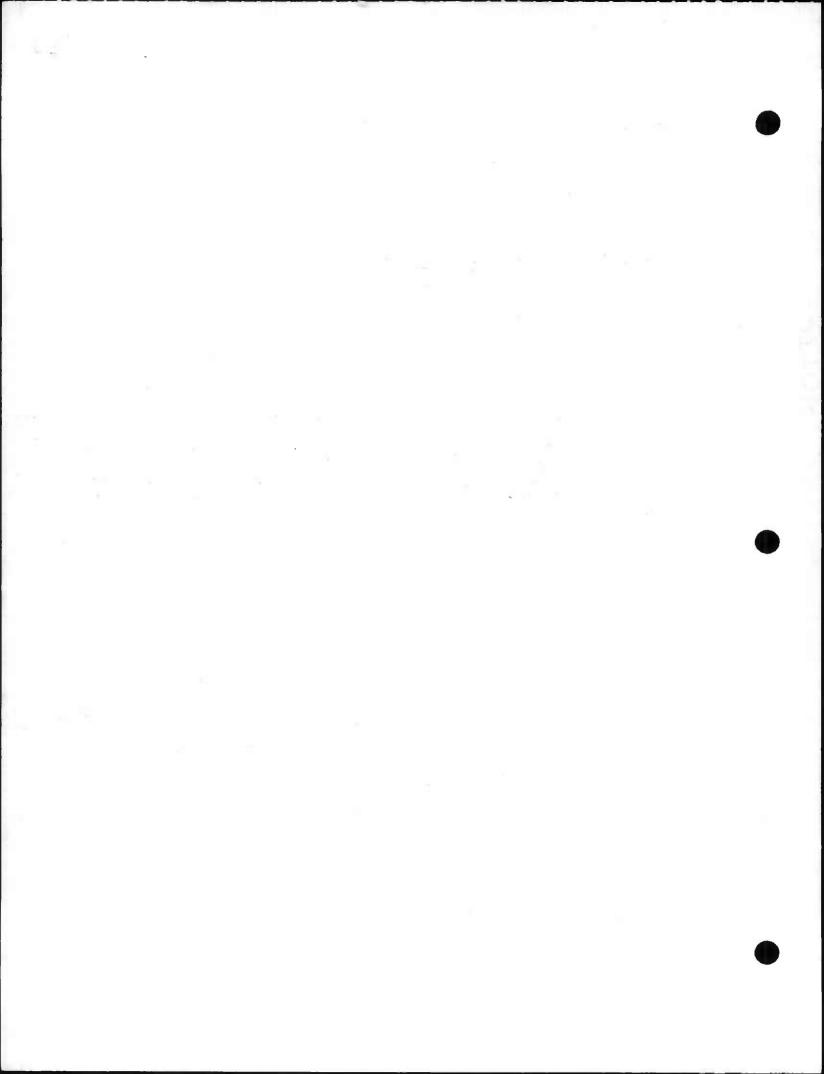
1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO

| | | REGISTRAN | | CENTIF | ICATE OF | DEALH | REG. NO | 1. | |
|---|------------|---|---|---|------------------|---|--|-------------------|---|
| | | 1. DECEDENT'S NAME (First, Middle, Lest) DOWAYNE | | PURN | FLI | | 2. DATE OF OEATH BONTH SEPTEMBER | | 3. TIME OF DEATH |
| | | 4. SOCIAL SECURITY NUMBER | | GE (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTN (Month, Day, Year) | , 8. | BIRTNPLACE (State or Foreign Country) |
| pinous | | 9a. FACILITY NAME (If not institution, give st | 1 M 2 F | XX YRS. | | OR LOCATION OF D | MARCH | 3/04 | Md |
| 2, 3 sho | ECTOR | THE JOHNS HOPKIN | , | | | ORE CITY | | 9c. COUNTY | OF DEATH |
| - | [당 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 1: 0: | | | | | |
| permit. Pages | E I | Md | | 10c. C11 | Ball | 6 | | | 10d. INSIDE CITY LIMITS? 1 CES 2 NO |
| nsit | VERAL | | ond 5 | t | 10 | 212 | 13 | U, S | of what country? |
| ding physician. | BY FUN | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Vivorced | 12. WAS DECEDENT EVE FORCES? 1 YE IF YES, GIVE WAR OF | ES 2 NO | If yes, sp | cendent of Hispai hecity Cuban, Mexico 5 2 NO Specifi | NIC ORIGIN? (Specify Year, Puarto Rican, atc.) | s or No 14. | RACE — American Indian, Black, White, atc. Specify: |
| r attend | | 15. DECEDENT'S EDUC (Specify only highest grade | | | USUAL OCCUPATION | | 16b. KIND OF BU | SINESS/INDUS | TRY |
| Spital or eed for u | TO BE | Elementary/Secondary (0-12) | College (1-4 or 5+) | IIIe. Do NOT u | sa retired.) | 4 | Sel | f | |
| # 6 E | | 17. FATHER'S NAME (First, Middle, Last) | | | 7 | 18. MOTHER'S NA | AME (First, Middle, Maiden | Sumame) | |
| retained 5 should | | 190, INFORMANT'S NAME (Type/Print) | 1 | 19b. MAILING 2 5 5 | ADDRESS (Street | and Number or Rural | Route Number, City or Tov | vn, State, Zip Co | rde) |
| 6 may be ector, page | | 20e. METNOD OF DISPOSITION 1 | oval from State | 20b. PLACE AND DATE cemelery, crematory or o | other place) | ame of D | | CATION - CITY | Cor Town, State |
| death. Page 6 m funeral director. I. examiner mus | | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE A | Breen | | ND ADDRESS OF FA | | | |
| after of the moval. | | 23. PART T. Enter the diseases, or c | O - O D Z | sed the death Do | Dot enter the mo | eles 9 | sineral | Hone | 1304h. Canha |
| | | immediate cause (Fine) | List Drily one cause or | n aech line. | | | | | interval Between Onaet and Death |
| with with pletel crema | | disease or condition resulting in deeth) | | S A CONSEQUENCE O | | ocarc | cinoma | | 6 mo |
| and and | NO | Sequentially list conditions, | DUE TO (OR A | S A CONSEQUENCE O | n: | | | | |
| ficate be ophysician ne prior to | RTIFICATIO | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | | S A CONSEQUENCE O | | | | | |
| ending ending | ш | that initiated events resulting in death) LAST | J | 3 A CONSCOUNCE O | r). | | | | |
| E Me e | 2 | PART II. Other eignificent condition | e contributing to deeti | h but npt recuiting | in the underlyin | g cause given in | Pert i. 24a. WAS AN | AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| that the the the the and the and | EDICAL | | | | | | PERFO | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| The law requires the has been sign ate Dept. of Heal em 23 shows | AN: ME | DID TOBACCO USE | CONTRIBUTE TO | O CAUSE O | F DEATH | YES N | ○ ⋈ | | 1 U YES 2 ND |
| PHYSICIAN: The law requires certificate has been with the State Dept. of rited, or litem 23 sho | SIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | NOSPITAL: | outpatient 3 DOA | OTHER: | LACE OF DEATN (Ch | 6 Other (Specify) | | |
| HYSICIA vis certif | РНҮ | 27. MANNER OF DEATH | 26e. DATE OF INJUF (Month, Day, Yea | RY 26b. TIA | IE OF 28c, IN. | JURY AT DRK? | 26d. DESCRIBE NOW | INJURY OCCUR | ED |
| ATTENDING PHYSICIAN: ECTOR: After this certificals after death with the St. 28 Is marked, or it | D BY | 1 Natural 5 Panding 2 Accident Investigation 3 Suicide 6 Could not be | 26e. PLACE OF INJU | JRY — At home, farm, | | YES 2 ND | 281. LOCATION (Street | | Rural Route Number, |
| DIRECTOR Hours after 18 | ETE | 4 Nomicide detarminad | building, etc. (S | | | | City or Town, State | | |
| 로 작전 = | COMPL | (Check only | CIAN: To the best of my kn | | | | | | ause(s) and manner as stated, |
| TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If | BE | 296. SIGNATURE AND TITLE OF CERTIFIER | Profesi | - MD | | 29c. LICENSE NUI | 9 S | 29d. DATE SI | SNED (Mogth, Day, Year) |
| 5 5 9 3 | 7 | 30. NAME AND ADDRESS OF PERSON WAS | $\Omega = 1$ | DEATN (ITEM 27) (Type | . Print) | | hms Hast | | |
| | 0 | 31. DATE ELLED SMORKY, SON, LOPULY | 32. REGISTRAR'S SI | IGNATURE | ouer | 110 30 | mis rugh | uns | USPITAL |
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| מאלים ביינים ומיינים ומיינים מ | certificate has been signed by the attending physician and completely filled in by the funeral dire- | |
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| | mpletely | with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
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| | FOR STATE REGISTRAR | STATE OF MA | | DEPARTM ERTIFICA | | | MENTA | L HYGIENI | E | | |
|---|--|--|--|--|-----------------|---|--|--|---|------------------------------------|---------------------------------|
| - (| 1. DECEDENT'S NAME (First, Middle, Last |) | | | | | | OF DEATH | | 3. T | ME OF DEATH |
| | CARMELLA | G. | PEN. | NINGTO | N | | AU(| | | 4' 1 | 0:45 A M |
| | 4. SOCIAL SECURITY NUMBER | | AGE (In yrs. las | t birthday) IF L | INDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | | OF BIRTH | 8. | Country | E (State or Foreign |
| | 578-04-3253 | 1 🗆 M 2 💢F | 23 | YRS. | THS UATS | HOURS MIN. | 06/ | 02771 | C | alif | ornia |
| œ | 9a. FACILITY NAME (If not institution, give | | | | | R LOCATION OF D | EATH | | 9c. COUNTY | - | |
| DIRECTOR | WOODS-ROLLING | ROAD & I | <u>-195</u> | | ATONS | SVILLE | | | BAL | TIMO | RE |
| REC | 10e. STATE 10b. COUN | TY | | 10c. CITY, TO | WN OR LOCAT | | | | | 10d. | INSIDE CITY |
| | | gomery | | | | Chevy | Chas | se | | 1 🗆 | YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER | *** 1 | | 010 | 101. | ZIP CODE | _ | | 10g. CITIZE | | COUNTRY? |
| N | 4242 East West | | | . 919 | | 2081 | | | | SA | |
| | | | | | | | Black, Whi | merican Indien, ie, etc. | | | |
| 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2X NO Specify: Sp | | | | | | | Specify: | nite | | | |
| COMPLETED | 15. DECEDENT'S ED (Specify only highest grad | UCATION de completed) | (G | CEDENT'S USUA | lone durina mas | N st of working | 16b | . KIND OF BUS | INESS/INDUS | | |
| | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. | Do NOT use retir | red.) | | | | | | |
| MP | 17. FATHER'S NAME (First, Middle, Last) | 5 | Sti | ıdent | - | 18. MOTHER'S N/ | | 11ege | | Sch | ool |
| S | J. Grant | Penningt | On | | | | | n A. I | | con | |
| 0 | 19e. INFORMANT'S NAME (Type/Print) | reminige | | . MAILING ADD | RESS (Street a | nd Number or Rural | | _ | | | |
| 유 | Jean A. Pennir | igton | 4: | 242 Ea | st We | st Hgw | y. A | pt.919 | Chevy | Chas | se,MD 2081 |
| | 20e. METHOD OF DISPOSITION 1 Burlal 2 Cremetion 3 Rec | moval from State | 20b. PLACE | AND DATE OF DIS | POSITION (Na | me of | DAT | F 20c LOC | ATION - CIN | or Town S | tate |
| | 4 Donetion 5 Other (Specify) | | letro | Crema | | Inc. | | 01 Bal | timo | re, l | MD |
| | 21. SIGNATURE OF FUNERAL SERVICE L | THE MA | 1 M | d | remat | ion So | ciet | v of | Marv | land | Inc. |
| | | Donald | WC | 2 | 99 Fr | ederic | k Ro | 1.Balt | imor | e, M | 21228 |
| | 23. PART I. Enter the diseases, or shock, or heart fallura | complications that c | aused the de | ath. Donot e | nter the mo | de of dying, aud | h as care | diac or respir | atory arreal | 1, | Approximate Interval Between |
| | IMMEDIATE CAUSE (Final | | | | | | | | | | Onset and Death |
| | disease or condition resulting in death) | | | | UN | WOUND | > | | | | |
| | | DUE 10 (OI | R AS A CONSE | DUENCE OF): | | | | | | | |
| RTIFICATION | Sequentially list conditions, if any, leading to immediate | b DUE TO (OF | R AS A CONSEC | DUENCE DF): | | | | | | | |
| § | cause. Enter UNDERLYING CAUSE (Disease or Injury | с | | | | | | | | | |
| | that initiated eventa resulting in death) LAST | DUE TO (OF | R AS A CONSEC | QUENCE OF): | | | | | | | |
| CER | Tooling in double 2.00 | d | | | | | | | | | |
| AL (| PART II. Other algolificant condition | ns contributing to de | ath but not r | eaulting in th | e underlying | cause given in | Part I. | 24a. WAS AN | | | AUTOPSY FINDINGS |
| | | | | | | | | 1 X YES 2 | | COM | PLETION OF CAUSE |
| MEDIC | | | | | | | | | | | YES 2 NO |
| ž | DID TOBACCO USE CON | TRIBUTE TO CAUS | | | | UNCERTAI | N 🗆 | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | HER: | | | | | | |
| H X | XXYES 2 \(\text{NO} \) | 1 Inpatient 2 E | | 28b. TIME OF | Nursing Home | 5 Residence | | CRIBE HOW IN | | ED | |
| | 27. MANNER OF DEATH | | | 1 S. AIM HIDY | WOI | | 200. DE | | | O | . 1 |
| | 1 Netural 5 Pending | 8-10-014 | FALLAD | 1045 TA | M 1 🗆 Y | ES 2 NO | C | UK TPCT | | CELL | |
| à | 1 Natural 5 Pending 2 Accident Investigation | 8 - Month Day 28e. PLACE OF II | FOUND AT he | FOUND | M 1 🗆 Y | ES 2 1 NO | 28f. LOC | ATION (Street of | nd Number or | SEL Rural Route I | lumber, M.D |
| à | 1 Natural 5 Pending 2 Accident Investigation | 8 - Month Day | HOUND HJURY — At ho (Specify) | me, farm, street, | M 1 🗆 Y | 7 | 28f. LOC City | ATION (Street et or Town, State) | | | NONSULLE |
| à | 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be datarmined | 8 - 10 - 0 4 | HUMP HURY — At ho (Specify) S NEA | me, ferm, street, | lectory, office | LOT | 281. LOC City PARK | ATION (Street or or Town, State) | ROLLINE | | lumber, MP MONSVILLE |
| à | 1 Netural 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be datarmined | 2ae. PLACE OF II building, etc | NJURY — At ho. (Specify) S NEA | me, farm, street, R A PA ath occurred at | Isctory, office | LOT | 281. LOC City PARK to the ceu | ATION (Street et or Town, State) RIDE see(s) end manual | ROLLING | RD C | |
| COMPLETED BY | 1 Netural 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be datarmined | 28e. PLACE OF II building, etc. W000 SICIAN: To the beat of my | NJURY — At ho. (Specify) S NEA | me, farm, street, R A PA ath occurred at | Isctory, office | LOT end place, end due eath occured at the 29c. LICENSE NU | 28f. LOC City PARK to the ceu | ATION (Street et or Town, State) RIDE see(s) end manual | ROLLING ner es stated. I due to the c | ause(s) end | menner ea stated. |
| BE COMPLETED BY | 1 Netural 2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only one) 29e. SIGNATURE AND TITLE OF CENTIFIER 29e. SIGNATURE AND TITLE OF CENTI | 3 - (Month Day 4 28e. PLACE Of WOOD) SICIAN: To the best of my IER: On the best of exam | NURY — At ho . (Specify) S NEA knowledge, da itnation and/or i | me, farm, street, R A PA with occurred at nivestigation, in | tectory, office | LOT end place, end due eath occured at the | 28f. LOC City PARK to the ceu | ATION (Street et or Town, State) RIDE see(s) end manual | ROLLING ner es stated. I due to the c | ause(s) end | menner en stated. |
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| 10 BE COMPLETED BY PI | 1 Netural 2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only one) 29e. SIGNATURE AND TITLE OF CENTIFIER 29e. SIGNATURE AND TITLE OF CENTI | SICIAN: To the best of my HO COMPLETED CAUSE Month | NJURY - At ho CSpecify) S NEA knowledge, da plination and/or i | me, farm, street, R A PA with occurred at niveatigation, in A 27) (Type, Print) | tectory, office | LOT end place, end due eath occured at the 29c. LICENSE NU | 28f. LOC City PARK to the ceu time, dete | ATION (Street et or Town, State) 2: RIDE use(s) end manuel end place, end | ROLLING | EUSE(s) end IGNED (Mont G.31 | n, Day, Year) |



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| PITAL OR ATTENDATE PRESIDANT. The law requires that the death certificate be executed writtin. Fours after de The Christian Ahar that scritting has been signed by the attending physician and completely filled in by the th The Arms after the Christian Christian and Mental Hydiene prior to burial, cremation, or removal. The frame of the many or fater 73 shows any Inlury, or other traumatic event, the medical exp. | s after death. Page 6 may be retained by the hospital or attending physician. | by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | emoval. | fical examiner must be notified at once. |
|---|---|---|---|--|
| HE FUNE ed within | HE HOSPITAL OF ATTENDING PAYSICIAN. The law requires that the death certificate be executed within. Thurs after death. Page 6 may be retained by the hospital or attending physician. | HE FUNERAL UNFECTOR. Ahur this contribute has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | ed within 72 multi and state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | DRTANT, if them 26 is married or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTI | | | REG. NO. | | | |
|--|--|---|--|--------------------------------------|---|---|-------------------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) Minnie Ma | rie Rau | | | | 2. DATE OF DEATH | W VEAR | 3. TIME OF DEATH 4:30 pm | |
| | 4. SOCIAL SECURITY NUMBER 220-12-5542 | | F UNDER 1 YEAR ONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) NOV . 14, 1 | L904 Ma | HPLACE (State or Foreign ry) | | |
| TOR | 9a. FACILITY NAME (If not institution, give standard Home RESIDENCE OF DECEDENT | reet and number) | 9 | | timore | ATH | Baltin | | |
| DIRECTOR | 10e. STATE 10b. COUNTY | timore | 10c. CITY, 1 | Baltin | ion iore 21.23 | l ₊ | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | |
| | | | | | | | | WHAT COUNTRY? | |
| 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO If Yes, apocity Cuban, Mexic IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPA If yes, apocity Cuban, Mexic 1 VES 2 NO Specification 15. WAS DECENDENT OF SPECIFICATION 16. YES 2 NO Specification 17. WAS DECENDENT OF SPECIFICATION 18. WAS DECENDENT OF SPECIFICATION 19. WAS DECENDENT OF SPECIFICATION 10. WAS DECENDENT OF SPECIFICATION 10. WAS DECENDENT OF SPECIFICATION 10. WAS DECENDENT OF SPECIFICATION 11. WAS DECENDENT OF SPECIFICATION 12. WAS DECENDENT OF SPECIFICATION 13. WAS DECENDENT OF SPECIFICATION 15. WAS DECENDENT OF SPECIFICATION 16. WAS DECENDENT OF SPECIFICATION 17. WAS DECENDENT OF SPECIFICATION 18. WAS DECENDENT OF SPECIFICATION 19. WAS DECENDENT OF SPECIFI | | | | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | WAL OCCUPATION to do during money and du | ON st of worlding | | memaker | | | |
| BE COM | 17. FATHER'S NAME (First, Middle, Last) William Fehre | er | | | | E (First, Middle, Meiden | | r | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) James R. Rau | | 195. MAILING AI 1810 Fo | rrest l | nd Number or Aural A | oute Number, City or Yown imore, Md. | 21234 | | |
| | 20s, METHOD OF DISPOSITION 1 (2 Burlet 2 Cremetion 3 Remo | P: | PLACEAND DATE OF netary, cremetory or other RYWOOD CO | emetery | Sept. 9 | 1994 Bal | cation — city or to Ltimore, | own, State Md. | |
| - 5 | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Mo | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate interval Between Onset and Dsath | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Due to (or as a consequence of): c. Due to (or as a consequence of): d | | | | | | | | | |
| VSICIAN: MEDICAL C | PART II, Other significent conditions MULTI | FORCT | g ceuse given in I | Part I, 244. WAS AN PERFOR 1 TYPES 2 | MED? | D. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 // NO | | | |
| ICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 26 PI | ACE OF DEATH (Che | ck only one) | | | |
| VAPAYS | 1 YES 2 NO 27. MANNES OF DEATH 1 Maturel 5 Pending Investigation | 1 Inpatient 2 ER/Outs 28a, DATE OF INJURY (Month, Day, Year) | 28b. TIME (| CHURSING Horr OF 28c. INJ Y WC | URY AT PRES 2 NO | Other (Specify) 28d. DESCRIBE HOW II | NJURY OCCURED | 10000 | |
| EO B | 3 Suicide 6 Could not be determined | 28e. PLACE OF INJURY building, etc. (Spec | — At home, farm, stre | et, factory, offic | | 281. LOCATION (Street a City or Town, State) | and Number or Rural | Route Number, | |
| COMPLE | | CIAN: To the best of my know | | | | | | e) end manner se stated. | |
| TO BE | 296 TIGHATURE AND TITLE OF CERTIFIER | Hal | ehan: | | D 2818 | S - | 29d. DATE SIGNE | 7 9 4 | |
| | 30. NAME AND ADDRESS OF PERSON WHO TASNEEM AKH 31. DATE-PIESD (MONTH). DAY HEAD | Action Table of De Action Table | PARIC | HEIG | HT A | VE BA | MY OT | 21208 | |
| | SEP 0 7 1994 | A man to the state of the | | | | | | | |

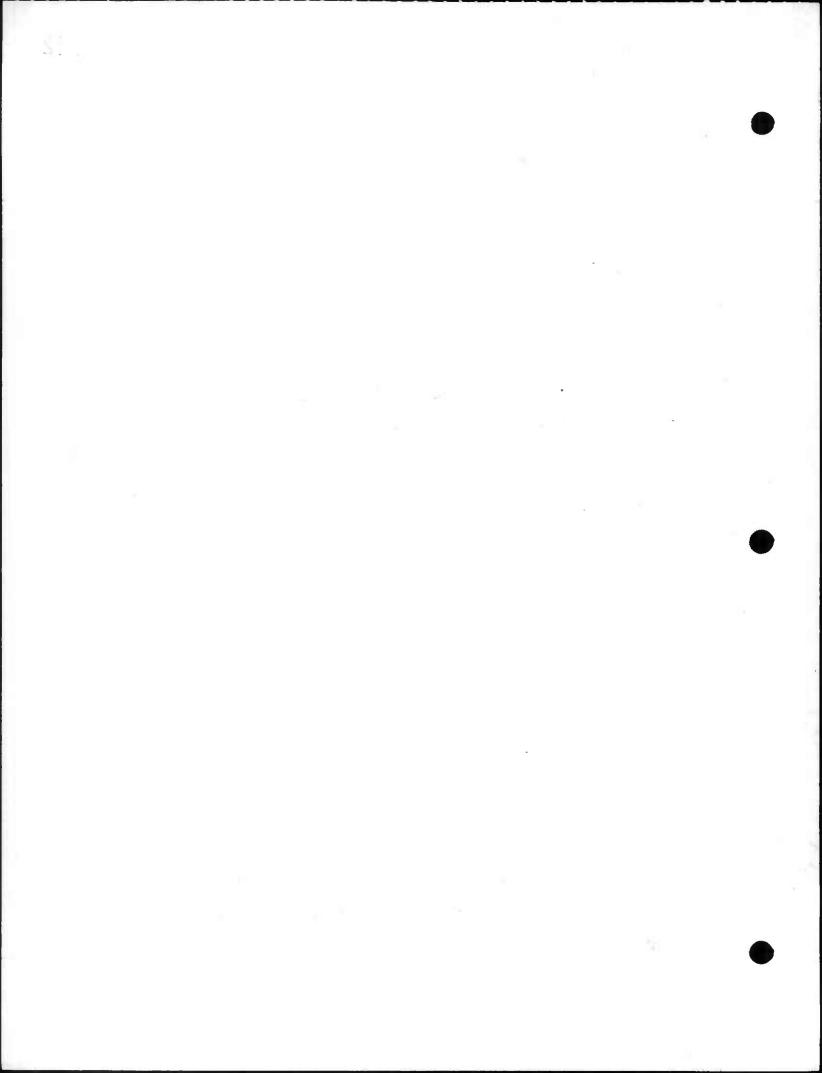
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DONALD G. WRIGHT
31. DATE FILED (Month, Day, Year)
SEP (1 1994

THE TENDING PHYSICIAN: The law requires that the death certificate be secoulted write the configuration of the configuration of the configuration of the certificate has been signed by the attending physician and completely fined in by the threath director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Highest prior to burial, committee, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760, OR ATTENDING PHYSICIAN: The law requires that the death certificant be executed with

| | L.R.B. | | | 9 l _s | 26122 | | | | | | | |
|--|--|--|--|---|--|--|----------|--------------------------------------|--|------------------------------------|------------------------------------|----------------|
| | FOR ITEMS: 27 | 7, PER MEO FILM G-716 10, STATE OF MARYLAND / DEPA | /14/94 t.t. | MENTAL HYGIENE | | | | | | | | |
| | REGISTRAR | CERTI | FICATE OF DEATH | REG. NO. | | | | | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | D | росшионамт Тм | 2. DATE OF DEATH | 3. TIME OF OEATH | | | | | | | |
| 1 | MICHAEL 4. SOCIAL SECURITY NUMBER | R . S. SEX S. AGE (in yrs. last birthda | ROSTKOWSKI Jr | | 1 1:20P M | | | | | | | |
| | 212-88-2800 | 1 ■ M 2 □ F 32 YRS | MONTHS DAVE MOURE MAN | (Month, Day, Year) 12 29 1961 | Country) MAPY JAA | | | | | | | |
| _ | 9e. FACILITY NAME (If not institution, give s | street and number) | 96. CITY, TOWN OR LOCATION OF D | | Y OF DEATH | | | | | | | |
| CTOR | FRANKLIN SQUA | RE HOSPITAL. | | BAI | TIMORE | | | | | | | |
| DIREC | 10e. STATE 10b. COUNT | Y 10c. C | CITY, TOWN DR LOCATION | | 10d. INSIDE CITY LIMITS? | | | | | | | |
| | MARYLAND BALL | limore | | | 1 YES 2 NO | | | | | | | |
| FUNERAL | 3 View Ridge | Drive | 21236 | 10g. CITIZE | N OF WHAT COUNTRY? | | | | | | | |
| S | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO | 13. WAS DECENDENT OF HISPA If yes, specify Cuben, Mexic | NIC ORIGIN? (Specify Yes or No.— 1 | I. RACE — American Indian, Black, White, etc. | | | | | | | |
| Β¥Ι | 1 Never Merried 2 Merried 3 Widowed 4 Divorced | IF YES, GIVE WAR DR DATES | 1 YES 2 ND Speci | | Specify: | | | | | | | |
| ETED | 15. DECEDENT'S EDU (Specify only highest grade | | I'S USUAL OCCUPATION | 16b. KIND OF BUSINESS/INDUS | BTRY | | | | | | | |
| | Elementary/Secondary (0-12) | | of work done during most of working ruse retired.) | T. 1. | | | | | | | | |
| Once. | 17. FATHER'S NAME (First, Middle, Last) | IRUC | K URIVER | IRUCKI | vg | | | | | | | |
| , i | Michael R. | RostKowski S | BON | AME (First, Middle, Melden Sumame) | DONALD | | | | | | | |
| OB | 19a. INFORMANT'S NAME (Type/Print) | | NG ADDRESS (Street and Number or Rural | Route Number, City or Town, State, Zip C | ode) | | | | | | | |
| Michael Rc Rostkowski Hudson St, 2518 BAlto. Md 21234 20e. METHOD OF DISPOSITION 20e | | | | | | | | | | | | |
| | | | | | | | examiner | · Malant | all in | W. DABROUSI | ALL ALLE POL | to NA 2.18 |
| | | | | | | | | 23. PART I. Enter the diseases, or o | complications that assed the death. Do | o not enter the mode of dying, suc | th as cardiac or respiratory arres | t, Approximate |
| E E | IMMEDIATE CAUSE (Final | List only one cause on each line. | | | Interval Between Onset and Death | | | | | | | |
| iii | disease or condition resulting in death) | . Head injurie | | | | | | | | | | |
| | | DUE TO JOR AS A EGNSEQUENCE | OF): | | | | | | | | | |
| RTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A CONSEQUENCE | OF): | | | | | | | | | |
| S | CAUSE (Disease or Injury | E | | | | | | | | | | |
| HTIFIC | that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE | OF); | | | | | | | | | |
| 5 5 | N DART II ON I - III- | | | | | | | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other significant condition | na contributing to death but not resulting | g in the underlying cause given in | Part I. 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO | | | | | | | |
| ED | | | | 1 X YES 2 □ NO | COMPLETION OF CAUSE OF DEATH? | | | | | | | |
| 2 2 | DID TOBACCO USE CONTI | RIBUTE TO CAUSE OF DEATH | YES NO UNCERTAL | $\overline{\square}$ | 1 TYES 2 NO | | | | | | | |
| YSICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | EATH (Check only one) | | | | | | | | | |
| IXSI | 1 TYPES 2 ND 27. MANNER DF DEATH | 1 X X Spatient 2 ER/Outpatient 3 DOA | The state of the s | | | | | | | | | |
| | 1 Netural 5 Pending | | IME OF 28c. INJURY AT WORK? M 1 YES 2 N. ND | SUBJECT FELL | RED | | | | | | | |
| D BY | 2 \(\sum \) Accident Investigation 3 \(\sum \) Suicide 8 \(\sum \) Could not be | 28e. PLACE DF INJURY — Al home, term building, etc. (Specify) | | 28t. LOCATION (Street end Number or | | | | | | | | |
| ETED | 4 Homicide determined | | ERGENCY ROOM | FRANKLIN SQUARE | MORE MD | | | | | | | |
| COMPLET | | ICIAN: To the best at my knowledge, death occu | | to the ceuse(e) end manner ee stated | | | | | | | | |
| Š | 2X MEDICAL EXAMINE | ER: On the beele of exemination end/or investiga | ition, in my opinion, death occured at the | time, date end place, end due to the | cause(e) end menner se stated. | | | | | | | |
| 2111 | 296. SIGNATURE AND TITLE DE CERTIFIE | 4 | 29c. LICENSE NU | | IGNED (Month, Day, Year) | | | | | | | |
| BE (| 1000000 1 91 | / 1/1/2 / L MAD | 0.C.M | | T 05 1994 | | | | | | | |

111 Penn Street, Baltimore, Maryland 21201.



use as the burial-transit permit. Pages 1, 2, 3 should

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36. NAME AND ADDRESS OF PERSON

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31. DATE FILED (MODIFILE)

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Poss 7:03 94 PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Yea 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR 1530 225 52 1 M 2 - F DAYS 5 YRS. 23/1936 10 Virginia Se. FACILITY NAME (If not institution, give street and o 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH University of Mary RESIDENCE OF DECEDENT Maryland DIRECTOR Himore 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Baltimore 1 X YES 2 | NO FUNERAL 10s. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2035 E. 32nd Street 21218 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 KNO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-I1 yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES ВҰ 1 TYES 2 MENO Specify: 3 Wildowed 4 Divorced Black COMPLETED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 166. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) unk. 0 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Freddie Ross Maggie Ross BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Elsie Bethea 2035 E. 32nd Street, Balto., MD 21218 20s. METHOD OF DISPOSITION
1 □ Burisl 2 Cremation 3 □ Ramoval from State
4 □ Donation 5 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, Slate Metro Crematory 9/10/94 Balto, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Albert P. Wylie, F/H P.A. 638 N. Gilmor St., Balto., MD 21217 23. PART I. Enter the diseases, or complicatione that caused the deeth. Do not enter the mode of dying, such as cerdisc or reapiratory arrest, shock, or heart failure. Liet only one ceuse on each line. Interval Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition Chrone aspers resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, If any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa reaulting in death) LAST PART II. Other aignificent conditione contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24h WERE AUTOPSY FINDINGS PHYSICIAN: MEDICAL AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? PERFORMED? 1 YES NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO [25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1/ Inpetient 2 - ER/Outpetient 3 - DOA OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 26s. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 26c. INJURY AT WORK? 26b. TIME OF 28d, DESCRIBE HOW INJURY OCCURED Netural : М 1 YES 2 NO BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 6 Could not be MARKETED 4 Homicide determined 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the ilme, data and place, and due to the cause(a) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the lime, data and place, and due to the cause(a) and menner as stated. AND TITLE OF CERTIFIE BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

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32. REGISTRAR'S SIGNATURE

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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Baltimore

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DHMH-16 Rev 1/89

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Interval Between

Onsat and Death

| CINISION OF VITAL MECONDS, F.O. BOX 887 80 | BALLIMORE, MARTLAND ZIZIS-0020 |
|---|--|
| OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | hours after death. Page 6 may be retained by the hospital or attending physician. |
| DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the hours after death with the State Dept. of Health and Mental Mygiene prior to burial, cremation, or removal. | DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should nours after death with the State Dept. or Health and Mental Hygiene prior to burial, cremation, or removal. |
| item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | medical examiner must be notified at once. |

DIRECTOR

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CERTIFICATION

MEDICAL

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ITEMS: 28a-f, PER MEO FILM G-716 10/14/94 t.t STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH BEG NO 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF OEATH SEPT 02 1994 10:25P DONALD LloyD RUSK 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH BIRTHPLACE (State or Foreign Country) (Month, Day, Year) 9/12/1933 MONTHS DAYS HOURS MIN. IN M 2 | F 60 VRS 219-28-0302 Balto., 9e. FACILITY NAME (if not institution, give street and number) 95 CITY TOWN OR LOCATION OF OFATH 9c. COUNTY OF CEATH 6300 BLOCK OF RT. 40 WEST BALTIMORE RESIDENCE OF DECEDENT 10e STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND Baltimore 1 YES 2 NO 10e. STREET AND NUMBER 10f. ZIP COOF 10g, CITIZEN OF WHAT COUNTRY? 3203 Gartside Avenue 21244 USA 12. WAS OECEOENT EVER IN U.S. ARMEO FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR OATES 11. MARITAL STATUS 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married Specify: 3 Wildowed 4 Divorced Black 16e. DECEOENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEOENT'S EOUCATION 16b, KINO OF BUSINESS/INOUSTRY (Specify only highest grad (Give kind of work done life. Do NOT use retired.) Social Security Adm. Elementary/Secondary (0-12) College (1-4 or 5 ±) Accountant 12th 1+ 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Lloyd Rusk Dorothy Tighlman 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saundra Rusk White 3203 Gartside Avenue Baltimore, MD 21244 20e. METHOD OF OISPOSITION

CO Buriel 2 Cremetion 3 Removal from State 20b. PLACE ANO DATE OF DISPOSITION (Name of 9/9/94DATE 20c. LOCATION -- City or Town, State cemetery, cremetery or other place) Garrison Forest Vet. Cem. 4 Donation /6 Dother (Specify) Owings Mills, MD H. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY

LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 23. PART LEnter tha diseases or complications that crusad the desth. Do not antar the moda of dying, such as cardiac or respiratory arrest, ura. List only one cause on each line. shock, or haart falura. List only one cause IMMEDIATE CAUSE (Final disease or condition se muries resulting in dasth) DUE TO (OR AS A CONSEQUENCE OF) Sequantially list conditions, QUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury **OUE TO (OR AS A CONSEQUENCE OF)** that initiated events. resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMEO? 1 YES 2 NO OF DEATH? DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one)

1 YES 2 NO HOSPITAL:
1 | Inpallent 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 NO 4 - Nursing Homa 5 - Realdence 8 Nother (Specify) ROADWAY 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 26c. INJURY AT WORK? 26d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 9:35 PM 1 YES 2 NO PEDESTRIAN STRUCK BY AUTO 9/2/94 Investigation 2 DCAccident 28e. PLACE OF INJURY — Al home, farm, atreet, factory, office building, atc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 4 Homicide determined 6300 BLK. RT. 40 WEST ROADWAY 29a, CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, date and piece, and due to the cause(e) and menner as stated.

2 XMEDICAL EXAMINER: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER

right MD

29c. LICENSE NUMBER O.C.M.E. 29d. OATE SIGNEO (Month, Day, Year) ▶SEPT 03 1994

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201. RIGHTMD 0,

SEP U / 1994

32. REGISTRAR'S SIGNATURE Dandon R.

| X 68760, BALTIMORE, MARYLAND 21215-0020 | TO THE MOSPITAL HIGHER ON PRINCIAN: The law requires that the death certificate be executed within mours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL INSTITUTE AND THE CENTIFICATE has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tran | to burial, cremation, or removal. |
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| WISION OF VITAL RECORDS, P.O. BOX 68760, | at PHYSICIAN: The law requires that the death certificate be | rentificate has been signed by the attending physician | be filed within 72 now man the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| OISIV | R ARTERDA | SCHOOL AS | Į |
| - | TO THE HOSPITAL | TO THE FUNERAL I | be filed within 72 ht |

| | 1 - STATE REGISTRAR | STATE OF MARY | | RTMENT OF ICATE OF | | REG. | NO. | | |
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| | Sula Conn Rachal 09 05 94 1: | | | | | | | 4 1:20 p | |
| | 233-32-3966 | 1 M 2 XF { | E (In yrs. last birthday) Res. | IF UNDER 1 YEAR MONTHS DAYS | HOURS MIN. | 7. DATE OF BIRTI (Month, Day, Ya. 09/10/ | nr) | Country) Texas | |
| стов | 9a. FACILITY NAME (# not institution, give Meridian Spa (| | | 96. CITY, TOWN | or Location of D | EATH | 1000 | of DEATH Arundel | |
| DIREC | 10a. STATE 10b. COUN | e Arundel | 10c. CIT | Y, TOWN OR LOC | Edgewa | tor | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| ERAL | 100. STREET AND NUMBER 3563 S. River | | | 1 | 01. ZIP CODE 2103 | | | N OF WHAT COUNTRY? | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR | S 2 NO | It yes, a | CENDENT OF HISPA | NIC ORIGIN? (Specifien, Puerto Ricen, etc. | y Yea or No — 1 | 4. RACE — American Indian, Black, Whita, atc. Specify: White | |
| LETED | 15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT u | work done during n se retired.) | | | BUSINESS/INDU | STRY | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) John Conn | 4 | Teache | r | | AME (First, Middle, Mi | , | School | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) Ernest A. Rach | | | | and Number or Rural | | Town, State, Zip C | MD 21037 | |
| | 20a. METHOD OF DISPOSITION 1 General Surface S | moval from State | 06. PLACE AND DATE | OF DISPOSITION (A | Vama of | DATE 20 | c. LOCATION — CI | ty or Town, State | |
| | 4 Donation 5 Other (Specify) Netro Crematory, Inc. 09/06 Baltimore, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald 22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 2122 23. PART 1. Enter the diseases, Dr complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate | | | | | | | | |
| ERTIFICATION | ahock, or heart failure immediate cause. Enter UNDERLYING CAUSE (Disease or condition resulting in death) Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST | a. DUE TO (OR AS | A CONSEQUENCE O | Facl Pi: | Ode of dying, aud | th ea cardlec or f | eapiratory arres | Approximate Interval Betwo Onset and De | |
| MEDICAL C | PART II. Other algnificent condition | ons contributing to deeth | but not resulting | in the underlyin | ng ceuse given in | PE | S AN AUTOPSY REORMED? | 24b. WERE AUTOPSY FINDIN AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| SICIAN: M | DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEA | | | NÆQ. | | 1 TES 2 NO | |
| BY PHYS | 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 1 Inpetient 2 ER/Ou 28a. DATE OF INJURY (Month, Day, Year) | 7 28b. TIM | E OF 28c. IN | me 5 Realdence JURY AT ORK? YES 2 NO | 6 Other (Specify, 26d, DESCRIBE H | OW INJURY OCCU | RED | |
| ETED E | 3 Suicide 8 Could not be 4 Homicide detarmined | 28e. PLACE OF INJUI building, atc. (Sp | RY — At home, tarm, secify) | street, factory, offi | ca | 28t. LOCATION (St City or Town, S | reet and Number or State) | Rural Route Number, | |
| COMPLE | | SICIAN: To the best of my known NER: On the basis of examinat | | | | | | cause(a) and menner as stated. | |
| O BE | 296 SIGNATURE AND TIPLE OF CERTIFE | 111 | _ | | 296-LICENSE NUI | MBER /92 | | 106/94 | |
| | ad name and address of Person w Richard Hochman | | EATH UTEM 27) /Бри 6 Murray | | ie Anna | polis, | MD 214 | i01 | |
| | 31. DATE ELLEP (MORITA PRO 1994 | 32. REGISTRAR'S SIG | NATURE | | | | | | |

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| 102 | hospital |
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| BALTIMORE, MARYLAND 21215 | fained hv |
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| MORE, | 6 шау |
| M | Page |
| BALTII | r death. Page 6 may be reft |
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| 9 | With |
| 687 | xecuted |
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| . B | ires that the death certificate b |
| P.C | th cer |
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|)RD | hat th |
| JF VITAL RECORDS, P.O. BOX 68760 | requires |
| 7 | WE! |
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| OF V | PHYSICIAN |
| DIVISION OF | TTENDING |
| DIV | DR A |
| | |

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | |
|---|--|---|-------------------|--|--|---|------------------|---|-----------|----|
| DIRECTOR | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH 3. TIME OF DEATN | | | | |
| | John H. Reisberg | | | | | Sent. | 6. 1994 | YEAR | M | |
| | 4. SOCIAL SECURITY NUMBER | ER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF U | | | IF UNDER 24 HRS. | 7. DATE OF BIRTN (Month, Day, Year) 8. BIRTNPLACE (State or Foreign Country) | | | Foreign | |
| | 213-12-8551 1 M 2 □ F 73 YRS. MONTH | | | ONTHS DAYS | HOURS MIN. | 12-18-1 | 920 | 20 Maryland | | |
| | 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, | | | | OR LOCATION OF DI | EATH | 9c. COUNT | 9c. COUNTY OF DEATH | | |
| | 3931 Old Hanover Road Westminster Carroll County | | | | | | | | | |
| Ä | 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR | | | | TION | | | 10d. INSIDE CITY LIMITS? | | |
| | | | | | estminster | | | 1 TYES 2 TO NO | | |
| FUNERAL | 10+. STREET AND NUMBER | | | | ZIP CODE | | 10g. CITIZE | 10g. CITIZEN OF WHAT COUNTRY? | | |
| | 3931 Old Hanover Road | | | | 21158 | | | U.S.A. | | |
| 필 | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMI FORCES? 1 YES 2 NO | | U.S. ARMED | Il yes, specify Cuben, Mexicen, Puarto Ric | | | | 4. RACE — American Inc. Black, White, atc. | Hen, | |
| BY | 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES | | | 1 TYES 2 NO Specify: | | | Specify: White | | | |
| | 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL | | | | | | | USINESS/INDUSTRY | | |
| | (Specify only highest grade of Elementary/Secondary (0-12) | completed) College (1-4 or 5+) | | rk done during mo | | | | | | |
| 길 | 7 | | Carper | nter | | Co | nstruct | ion | | |
| COMPLETED | The state of the s | | | | 18. MOTNER'S NA | R'S NAME (First, Middle, Malden Surname) | | | | |
| BE C | Hugo W. Reisberg | | | | Ruth Green | | | | | |
| 5 | | | | | end Number or Rural Route Number, City or Town, State, Zip Code) | | | | | |
| - | Mrs. Augusta M. | Reisberg | 3931 | 01d Ha | nover Ro | ad Westm | inster, | MD 21158 | | |
| | 20a. METHOD OF DISPOSITION 1 X Buriel 2 Cremetion 3 Remove | val from State 20b. | PLACE AND DATE OF | DISPOSITION (Na | me of | DATE 20 | c. LOCATION — CI | ty or Town, Slate | | |
| 4 Donetton 5 Other (Specify) Wards Chapel Cemetery 9/8/94 Randa | | | | | | | | stown, MD | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | |
| Sykesville, MD 21784 (410)-79 | | | | | | | | | | |
| | 23. PART I. Enter the diseeses, or conshock, or heart fellure. L | implications that cased | the death. Do not | enter the mo | de of dylng, auc | h as cardiac or i | espiratory arres | Approxir | | |
| | IMMEDIATE CAUSE (Fine) | | | ^ | | | | Onset er | | |
| | disease or condition resulting in desth) e. Resperatory factors | | | | | | | | | |
| NO | disease or condition resulting in desth) e. Conservating fulling. Due to (or as a conscouence of): Sequentially list conditions, Due to (or as a conscouence of): | | | | | | | | | |
| | | | | | | | | | | AT |
| 띮 | CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | |
| | PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | | |
| CAL | PERFORMED? AMA | | | | | | | 24b. WERE AUTOPSY AWAILABLE PRIOR | OT F | |
| | 1 🗆 YES 2 | | | | | S 2 NO | OF DEATH? | | | |
| Σ | DID TORACCO LISE CONTR | IDLITE TO CALIEF O | F DEATH VEC | D NO E | LINICEDTALI | | | 1 _ YES 2 _ | NO | |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | | |
| SIC | EXAMINER? HOSPITAL: OTHER | | | | | | | | | |
| Ä | 27. MANNER OF DEATN | 26e. DATE OF INJURY 28b. TIME OF 28c. INJURY A | | | | | | | | |
| | 1 Natural 5 Pending | INJUF | 10.7 | RK? (ES 2 NO | | | | | | |
| р Вү | 3 Suicide 26e. PLACE OF INJURY — Al home, fer | | | m, street, fectory, office | | 281. LOCATION (Street and Number or Rural Route Number, | | | | |
| Ē | 4 Homicide determined building, atc. (Specify) | | | | | | | | - 1 | |
| COMPLETED | 29e. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, end due to the ceuse(s) end manner es attend. | | | | | | | | | |
| N N | one) 2 MEDICAL EXAMINER: On the bests of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated. | | | | | | | | | |
| | 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | |
| H | Showing (lleni pun | | | | 041725 916194 | | | | | |
| O 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) | | | | | | | | | 1 1-1-1-1 | |
| | SHARONY ALO | BLUR | . Wi | 57m17578 | am : | | | | | |
| | 31. DATE FILED (Month, Day, Year) 1994 | 32. REGISTRANS SIGNA | THE S | | | | | 21157 | | |

Ε. Roberta Remley 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 DAYS HOURS 1 M 2 F YRS. 99 220 20 7290 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION DIRECTOR Sykesville Eldercare Sykesville 10e. STATE 10b. COUNTY 10c, City, TOWN OR LOCATION Maryland Carroll County Sykesville permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE funeral director, page 5 should be detached for use as the burial-transit 7309 Second Avenue rurs after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11 MARITAL STATUS 13. WAS DECENDENT OF BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Merried If yes, specify Cuben, IF YES, GIVE WAR OR DATES 1 YES 2X NO BY 3 Wildowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) ry/Secondary (0-12) College (1-4 or 5+) 12 Secretary 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER 7 38 John W. Blizzard notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or 2 Mr. Darrell Blizzard 14609 Burntwoods R 9 20e. METHOD OF DISPOSITION
1 ☐ Burlel 2 🎇 Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of must 4 Donation 5 Other (Specify) Carroll Cremation Ser examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS Suan a. Avalo signed by the attending physician and completely filled in by the Health and Mental Hygiene prior to burial, cremation, or removal. P.O. Box 195 the medical 23. PART i. Enter the disesses, or complications that caused the death. On not enter the mode of dying. shock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final disesse or condition 12 Leaners event, reculting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury or other that initiated evente resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): shows any injury, PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause give MEDICAL has been : PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCER item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h h the State I d, or item HOSPITAL: 1 750 2 RO ATTENDING PHYSICIAN: 1 | Inpetient 2 | ER/Outpetient 3 | 4 Nursing Nome 5 Reald DIRECTOR: After this cen hours after death with the Item 28 is marked, o 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 Nittural 5 Pending 1 YES 2 N BY Investigation 2 Accident 3 Sulcide 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 8 Could not be determined COMPLETED 4 Homicide OR 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, en TO THE HOSPITAL OF TO THE FUNERAL D be filed within 72 ho 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred 29b. SIGNATURE AND TITLE OF CERTIFIER H

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

22. REGISTRAR'S SIGNATURE

1 - FOR STATE REGISTRAR

2

31. DATE FILED (Month; Day, Year)

SFP

7 1994

1. DECEDENT'S NAME (First, Middle, Last)

| STATE OF MA | ARYLANI |) / DEPART | CATE (| F HEALTH AND | MENTAL HYGIE REG. N | | | |
|-----------------------------------|-----------------------------|--------------------|---------------|---|---|--------------------|----------------|---|
| Ε. | Rem1 | | | | 2. DATE OF DEATH MONTH 9 1 | DAY 94 | YEAR | 3. TIME OF DEATH 12:10 P. M |
| | | s. last birthday) | IF UNDER 1 YE | EAR IF UNDER 24 HRS. | 7. DATE OF BIRTN | ンサ | s sign | IZ: 1U P. M |
| □ M 2 □ F | 99 | | MONTHS DA | AYS HOURS MIN. | (Month, Day, Year) Sept. 25 | | Countr | aryland |
| t and number) | | | 9b. CITY, TO | WN OR LOCATION OF D | EATN | 9c. COU | JNTY OF D | EATH |
| care | | | Syke | sville | | | Carr | 011 |
| oll Coun | ıty | | ykesv | | | | | 10d. INSIDE CITY LIMITS? 1(YES 2 NO |
| | | | | 101. ZIP CODE | | 10g. CIT | IZEN OF V | WHAT COUNTRY? |
| Avenue | | | | 2178 | 24 | | U.S. | ٨ |
| . WAS DECEDENT I | | | 13. WAS | DECENDENT OF HISPA | NIC ORIGIN? (Specify Y | | 14. RACE | - American Indian, |
| FORCES? 1 | | \XNO | | s, specify Cuben, Mexic YES 2X NO Speci | | | Black Speci | k, White, etc. |
| 0 1 20 10 | | | | 250 | | | | White |
| ION npleted) | 18e | . DECEDENT'S U | JSUAL OCCUP | PATION ng most of working | .16b. KIND OF B | USINESS/IN | DUSTRY | |
| College (1-4 or 5+) | | life. Do NOT use | retired.) | g most or working | | | | |
| | | Secr | etarv | | | Cle | rica | 1 |
| | | - | | 18. MOTNER'S N | AME (First, Middle, Maide | | L. H. Left | |
| zard | | | | Mir | nie R. Er | h | | |
| | | 19b. MAILING | ADDRESS (St | reet and Number or Rural | | | in Code) | |
| ard | | | | twoods Roa | | | | 20 |
| | Tanh PLA | CEANDDATEO | | | | OCATION - | | |
| I from State | cemetery. | , crematory or oth | ner placel | | | | | |
| SEE / | l Va | rroll | Crema | tion Serv. | 9/5/94 | Hamps | tead, | MD |
| Dais | At | | | | Haight Fu | | | |
| nplications that o | caused the | death. Dp no | t enter the | Box 195 S mode of dying, suc | ykesville ch aa cerdlec or ree | Md piratory er | 2178 reet, | Approximate interval Between |
| A12 | Lee | Laus | Di | Sec-2 | > | | | Onset end Desth |
| DUE TO (O | IR AS A CON | NSEQUENCE OF) | | | | | | |
| DUE TO (O | R AS A CON | NSEQUENCE OF) | : | | | | | |
| DUE TO (O | R AS A CON | NSEQUENCE OF) | * | | | | | |
| | - | | | | | | | |
| ontributing to de | eeth but nr | ot resulting in | the under | lying ceuee given in | Part I. 24s. WAS A | N AUTOPSY | 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| 200 | سكا | معمد | 1 2 | Terosa | 1 TYES | 0 | | COMPLETION OF CAUSE |
| | | | | | | T Partie | | OF DEATH? |
| SUTE TO CAU | | | | | N 🗆 | | | 1 YES 2 NO |
| OSPITAL: | 26. Pf | PLACE OF DEATH | | one) | | | | |
| ☐ Inpetient 2 ☐ E | ER/Outpetien | | OTHER: | Nome 5 - Reeldence | 6 Other (Specify) | | | |
| 28e. DATE OF IN. (Month, Day, | JURY Year) | 28b. TIME INJU | IRY | WORK? | 28d. DESCRIBE NOW | INJURY OC | CURED | |
| 28e. PLACE OF II building, etc | injury — Ar c. (Specify) | t home, ferm, str | | | 281. LOCATION (Stree City or Town, State | t end Number e) | r or Rural A | loute Number, |
| | | | | | | | | |
| | | | | date end piece, end due on, death occured at the | | | |) end menner ee stated. |
| | 11 | | | 29c. LICENSE NU | MBER | 29d. DAT | E SIGNED | (Month, Day, Year) |
| me | N | | | 12/15 | 17) | | 115 | 1094 |
| OMPLETED CAUSE | OF DEATH (I | (ITEM 27) (Type, F | Print) | | | | | |
| 20 REGISTRAD'S | C CICNATUR | - | | | | | | |

3 .

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1 - STATE REGISTRAR | STATE OF MARYLAND | / DEPARTMENT OF ERTIFICATE O | | AL HYGIENE BEG NO | | |
|--|--|--|--|--|--|-----------|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DA | TE OF DEATH | 3. TIME OF DEATH | |
| NORMAN W | . SE | IFERT . III | SE SE | PT. 1 | 94 6:20 | Ам |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (In yrs. In | | R IF UNDER 24 HRS. 7. DA | TE OF BIRTH onth, Day, Year) | 8. BIRTHPLACE (State or Fore | |
| | 1X M 2 □ F 23 | YRS. MONTHS DAY | | 17P1 2 H284 | MARYLAND | |
| 9e. FACILITY NAME (If not institution, give street | et and number) | 9b. CITY, TOW | N OR LOCATION OF DEATH | 7.7 | OUNTY OF DEATH | |
| 11415 GLEN ARM | ROAD_ | GLEN | ARM | B | ALTIMORE | |
| RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10c. CITY, TOWN OR LO | CATION | | 10d. INSIDE CITY | |
| Maeylam Bell | imar | 02/2 | ARM | | LIMITS? | 10 |
| 10a. STREET AND NUMBER | 11 10 82 | GLAT | 10f. ZIP CODE | 10g. (| CITIZEN OF WHAT COUNTRY? | |
| 11415 (2)50 AR | m Roso | | 21000 | | 1158 | |
| 11. MARITAL STATUS | 2. WAS DECEDENT EVER IN U.S. A | | ECENDENT OF HISPANIC ORI | | - 14. RACE - American Indian | ١, |
| 1 Never Merried 2 Married 3 Widowed 4 Divorced | FORCES? 1 YES 2 | | specify Cuban, Maxican, Puar ES 2 NO Specify: | to Rican, etc.) | Black, White, etc. Specify: | |
| | | | | | ELIKA | |
| 15. DECEDENT'S EDUCA' (Specify only highest grade co | impleted) (| DECEDENT'S USUAL OCCUPA Give kind of work done during to. Do NOT use retired.) | TION most of working | 66. KIND OF BUSINESS | INDUSTRY | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | 1119 | 105326 775 | 16. MOTHER'S NAME (FIG. | e blidelle bledde Common | -1 | |
| DARMAN H S | 1927.2 | | King Ko | - 1. | | |
| 19a. INFORMANT'S NAME (Type/Print) | 1 | 9b. MAILING ADDRESS (Street | et and Number or Rural Route No | | Zin Corte | _ |
| Kinika S. PL | TOHIR S | 223 lunku | 200 | SRO MAR | 211000 21111 | 6 |
| 20a. METHOD OF DISPOSITION | 20b. PLACE | AND DATE OF DISPOSITION | | | — City or Town, State | <u> </u> |
| 1 Donation 5 Other (Specify) | al trom State cemetery, co | rematory or other place) | & VACIANIS | E RAIT | MARY MARYLA | 00 |
| 31. SIGNATURE OF FUNERAL SERVICE LICEN | | 22 NAME | AND ADDRESS OF FACILITY | 00 | 11000 | 1130 |
| 100 | Å | 279 | IN CHAPLLO | 1000 | 2 1 11 | |
| 23. PART I. Enter the diseeses, or con | mplicetions that caused the d | leeth. Do not enter the | node of dving, such ea c | erdiec or respiratory | errest, Approximat | ia . |
| shock, or heart fellure. Lis | st only one cause on each ilm | ie. | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | Interval Bat | ween |
| iMMEDIATE CAUSE (Final disease or condition | 0013:103: 01110103: | | | | Onset and | Death |
| resulting in death) e. | DUE TO (OR AS A CONSI | | | | | |
| | , | , | | | į | |
| Sequentially list conditions, if any, leading to immediate | OUE TO (OR AS A CONSE | EOUENCE OF): | | | | |
| cause. Enter UNDERLYING | | | | | | |
| CAUSE (Disease or Injury that initiated events | | | | | | |
| | OUE TO (OR AS A CONSE | EOUENCE OF): | _ | | | |
| resulting in deeth) LAST | OUE TO (OR AS A CONSI | EOUENCE OF): | | | | |
| d., | | | ring cause given in Part I. | 24s. WAS AN AUTOP | SY 24h WERF ALIYOPSY FIN | DINGS |
| PART II. Other significant conditions | | | ring cause given in Part I. | PERFORMEO? | AVAILABLE PRIOR TO | 0 |
| d., | | | ing cause given in Part I. | | AVAILABLE PRIOR TO COMPLETION DF CA DF DEATH? | USE |
| PART ii. Other significant conditions | contributing to death but not | resulting in the underly | | PERFORMEO? | AVAILABLE PRIOR TO COMPLETION DF CA | USE |
| PART II. Other significant conditions DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL | contributing to death but not | resulting in the underly | □ UNCERTAIN □ | PERFORMEO? | AVAILABLE PRIOR TO COMPLETION DF CA DF DEATH? | USE |
| DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | BUTE TO CAUSE OF DEA | ATH YES NO MCE OF DEATH (Check only o | UNCERTAIN D | PERFORMEO? | AVAILABLE PRIOR TO COMPLETION DF CA DF DEATH? | USE |
| DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | BUTE TO CAUSE OF DE. 26. PLA 1OSPITAL: Inpetient 2 ER/Outpatient 28e. DATE OF INJURY | ATH YES NO ACE OF DEATH (Check only o OTHER: 3 DOA 4 OTHER: 28b. TIME OF 28c. | UNCERTAIN Depois | PERFORMEO? | AMALABLE PRIOR TO COMPLETION DF CAD DF DEATH? 1 YES 2 NO | USE |
| DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXYES 2 \(\text{NO} \) 27. MANNER OF DEATH 1 \(\text{Netural} \) 5 \(\text{Pending} \) | BUTE TO CAUSE OF DE. 26. PLA OSPITAL: Inpatient 2 = ER/Outpetient 28e. DATE OF INJURY (Month, Dey, Veer) | ATH YES NO NOTHER: ATH OTHER: DOA 4 Nursing H ATH YES SO NO OTHER: A Unraing H A Unraing H A Unraing H A Unraing H A Unraing H A Unraing H | UNCERTAIN Down | PERFORMEO? 1 YES 2 NO Wher (Specify) DESCRIBE HOW INJURY | AMALABLE PRIOR TO COMPLETION DF CA DF DEATH? 1 YES 2 NO | USE |
| DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XYES 2 NO 1 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | BUTE TO CAUSE OF DE/ 26. PLA HOSPITAL: Inpetient 2 ER/Outpetient 28a. DATE OF INJURY (Month, Day, Year) 9-1-94 28a. PLACE OF INJURY — At h | ATH YES NO NCE OF DEATH (Check only of the Nursing Health Nursing | UNCERTAIN Done X XRaeldence 5 On INJURY AT WORK? YES 2 (NO SUB, William 281. L.) | PERFORMEO? 1 Syes 2 No ther (Specify) DECT SHOT SEL DOCATION (Street and Num | AMALABLE PRIOR TO COMPLETION DE CA DE DEATH? 1 YES 2 NO OCCUREO | USE |
| DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXYES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 1 Investigation | BUTE TO CAUSE OF DE. 26. PLA 1OSPITAL: Inpetient 2 ER/Outpetient 280. DATE OF INJURY (Month, Day, 'Year) 9-1-94 | ATH YES NO NCE OF DEATH (Check only of the Nursing Health Nursing | UNCERTAIN Done X X Residence 5 Or INJURY AT WORK? YES 2 (NO SUB. | PERFORMEO? 1 Styes 2 NO Sther (Specify) DESCRIBE HOW INJURY IN DECT SHOT SEL DOCATION (Street and Numity or Town, State) 1 1 4 1 | AMALABLE PRIOR TY COMPLETION DF CA DF DEATH? 1 YES 2 NO OCCUREO | USE |
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| BALTIMORE, MARYLAND 21215-0020 | er death, Page 6 may be retained by the hosping a man an physician. | the funeral director, page 5 should be detach function in burial-transit permit. Pages 1, 2, 3 should wal. | if examiner must be notified at once. | TO BE COMPLETED BY FUNERAL DIRECTOR |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The Jaw requires that the death certificate be executed within 2x fours after death, Page 6 may be retained by the hosping armining physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach funeral man burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION |

| | | | | | | 94 | 20123 |
|-------------|--|--|--|--|---|--------------------|---|
| | Item 1, g-715, 9-7- | 94, per F.H., dr | | | | | |
| | FOR STATE REGISTRAR | STATE OF MARYLAND | | T OF HEALTH AND | MENTAL HYGIEN | | |
| | 1. DEGEDENT'S NAME (First, Middle, Last) | Clini | , | | 2. DATE OF DEATN | | 3. TIME OF DEATH |
| | ->611A1A00 | CIVA 1 | IVIAN | SCRIVNOR | 9" 0 | 6 94 | 1205 11 |
| | 010 | 5. SEX 6. AGE (In yrs. I | lest birthday) IF UNDE | THE TYPE IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | INPLACE (State or Foreign |
| | 21/100/00 | 10 M 2 XF 83 | YRS. | DAYS HOURS MIN. | 8-31-1 | IN | |
| ~ | 9a. FACILITY NAME (If not institution, give stre | | | Y, TOWN OR LOCATION OF I | | 9c. COUNTY OF | |
| DIRECTOR | MERIDIAN NUTSI | NG LOCH RAI | VEN ! | BALTIMOR | KE | BAL | TIMORE |
| ÆC | 10a. STATE 10b. COUNTY | | 10c. CITY, TOWN | OR LOCATION | | | 10d. INSIDE CITY |
| ā | MId. BAI | -TIMOre | LUTT | HERVILLE | | | LIMITS? 1 YES 2 NO |
| AL | 10e. STREET AND NUMBER | | | 101. ZIP CODE | | 10g. CITIZEN OF | WHAT COUNTRY? |
| Ē | 1617 Charmi | ITH Kd, | | 21093 | | USA | \ |
| FUNERAL | | 12. WAS DECEDENT EVER IN U.S. FORCES? 1 \(\subseteq \text{YES} \) 2 | ARMED 13 | . WAS DECENDENT OF NISP/ If yes, specify Cuben, Mexic | | or No- 14. RA | CE — American Indian, ck, White, etc. |
| ВУ | 1 Never Merried 2 Married 3 W Widowed 4 Divorced | IF YES, GIVE WAR OR DATES | (no | 1 VES 2 NO Spec | | | city: |
| | 15. DECEDENT'S EDUCA | TION | | | | IW | HITE |
| | (Specify only highest grade co | ompleted) | DECEDENT'S USUAL (Give kind of work done fie. Do NOT use retired. | during most of working | 16b. KIND OF BUS | SINESS/INDUSTRY | |
| <u>P</u> | Elementary/Secondary (0-12) | College (1-4 or 5+) | SALES (| Clerk | HET | AIL | |
| COMPLETED | 17. FATNER'S NAME (First, Middle, Last) | | | | AME (First, Middle, Maiden | Sumame) | |
| ш | William STO | ORM | | En | \ | NG | |
| B | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING ADDRES | S (Street and Number or Rura. | 1111 | | |
| ٤ | JAMES L.S | CRIVNOR | 1100 | DAIRY R | | | Nd. 21120 |
| | 20a, METHOD OF DISPOSITION 1 Surial 2 Cremation 3 Remove | 20b. PLAC | E AND DATE OF DISPO | SITION (Name of | DATE 200 LO | CATION — City or | |
| | 4 Donation 5 Other (Specify) | HERF | FORD BA | Prist Church | en 9/8/99 HE | REFOR | D. Md. |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | JAMES . | 1 00 | ****** **** **** | | | |
| | Westert Wel | thouse | | vans Char 325 York | el of Chim | | ld. 21093 |
| | 23. PART I. Enter the diseases, or cor | mplicatione that caused the o | deeth. Do not ente | r the mode of dying, su | ch as cardiec or respi | ratory arrest, | Approximate |
| | enock, or heert fellure. Lie iMMEDIATE CAUSE (Final | et only one cause on each lin | ie. | . 60 | 1 1 | | Intarval Between Onset and Death |
| | disease or condition resulting in death) | Canci | on a | 1 (K) | Greant. | | and |
| - 1 | reading in death) | DUE TO JOB AS A COME | EQUENCE OF | 1 | o cerco | | 1 / man |
| Z | Samusanialis list and distant | Bone | Metas | lases | 1127 | | 3 north |
| ١Ę | Sequentially list conditions, if any, leading to immediate | DUE TO JOH AS A CONS | EQUENCE OF | - 01. 01 | 1-1 | | O MAN |
| RTIFICATION | CAUSE (Disease or injury | DUE TO JOH AS A CONS | wells | Mell | ello | | |
| Ē | that initiated events resulting in death) LAST | O TOTOM AS A CONS | OOGHCE OF): | 1 | 11. | | |
| E | 4. | Corma | M / | meny 1 | nonffice | ency | |
| | PART II. Other significant conditions | contributing to death but not | resulting in the u | nderlying couse given in | Part I. / CAR. WAS AN | | b. WERE AUTOPSY FINDINGS |
| MEDICAL | · | | | V | PERFOR | | AWAILABLE PRIOR TO COMPLETION OF CAUSE |
| W I | | | | | / | | T YES NO |
| ż | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 13-4- | 26. PLACE OF DEATH (C | neck unty one) | | |
| YS. | 1 VES 2 ANO | ☐ Inpatient 2 ☐ ER/Outpatient | 3 DOA 4 NO | R: ming Home 5 🗌 Residence | 6 🗆 Other (Specify) | | |
| E | 1 Netural 5 Pending | 28s. DATE OF INJUSTY (Month, Day, Year) | 286. TIME OF INJURY | 28c, INJURY AT WORK? | 38d. DESCRIBE HOW IS | HUNY OCCURED | |
| B | Accident investigation | 74. N. 407. CT | | 1 YES 2 NO | | | |
| 9 | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — At h building, etc. (Specify) | iome, farm, atreet, fac | dary, office | 28f. LOCATION (Street a City or Town, State) | nd Number or Rural | Route Number, |
| 5 H | an continue | | | | | | |
| OMPL | (Check only | AN: To the best of my knowledge, o | | | | | |
| ō | MEDICAL EXAMINER: | On the beals of examination end/or | r investigation in my | opinion, death occured at the | e time, date and place, and | d due to the cause | (a) and menner as stated. |

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EIDN Alter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be made that the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. TO THE OSPITAL ASTERMINE PHYSICIAN: The law requires that the death certificate be executed with rouns after death. Page 6 may be retained by the host TO THE HAVE LIBERTON ASTERMINED TO THE HAVE THE CONTINUE OF THE CONTINUE CONTINUE OF TH

| | | | | | | | | | | 96 | 1 6 | 20130 |
|--------------|--|---------------------------|------------------------------------|-------------------------|-------------|--------------|----------------|------------|--|---------------|---------------|---|
| | 1 - FOR STATE REGISTRAR | STATE OF N | IARYLAND / | DEPAR | RTMEN | T OF H | IEALTH DEAT | AND I | MENTAL HYGIEI REG. NO | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | -0.0 | | | | | 2. DATE OF DEATH | DAY | YEAR | 3. TIME OF DEATH |
| | WILLIAM S. | SIM | | SR | | | | | | | 74 | 4.20 PM |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (in yrs. les | st birthday) | | R t YEAR | IF UNDER | | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTHI | PLACE (State or Foreign |
| | 0.0 | 1 X M 2 - F | 76 | YRS. | MONTHS | DAYS | HOURS | MIN. | 9-14-1 | 7 | m | b . |
| ~ | 9e. FACILITY NAME (If not institution, give str | | | | 9b. CIT | | R LOCATIO | | | | NTY OF DE | |
| DIRECTOR | MONOR CARE- | · Tow | 500 | | | 70 | ws | 02 | | BAL | TIP | nore |
| EG | RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY | | | T inc. Cit | v TOWN | OR LOCAT | ION | | | | $\overline{}$ | 10d. INSIDE CITY |
| SIR | The second secon | TIMO | 16 | | | RNE | | | | | | LIMITS? |
| _ | 10e. STREET AND NUMBER | | | | | | . ZIP CODE | | | T 100 CITIZ | | 1 ∐ YES 2 ₩ NO |
| ERA | | CRD R | 0 | | | | 212 | | | _ | S. | A |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDEN | | MED | 13. | WAS DEC | | | IIC ORIGIN? (Specify Ye | | | - American Indian, |
| | 1 Never Merried 2 Merried | | YES 2 | | - 1 | If yee, spi | ecify Cuba | n, Mexical | n, Puerto Rican, etc.) | 01 143 | Black, | , White, etc. |
| ВУ | 3 Widowed 4 Divorced | | All on philo | | | 1 🗀 165 | 2 100 | Specif | <i>/:</i> | - le | Specif W H | TITE |
| 8 | 15. DECEDENT'S EDUC. (Specify only highest grade of | | 16e. DE | CEDENT'S | USUAL C | CCUPATIO | ON of workin | | 16b. KIND OF BU | SINESS/IND | USTRY | |
| ET | Elementary/Secondery (0-12) | College (1-4 or 5 + | | ive kind of Do NOT u | | | | | | | | |
| COMPL | | | me | CHA | 2 ICV | LF | ore | man | RAIL | ROAL | 2 | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) ISAAC FRANC | 5 | 1.00 | | | | | | ME (First, Middle, Maide | - 4 | | |
| BE | | C17 2 | | | | | | | | 166 | _ | |
| 0 | 190. INFORMANT'S NAME (Type/Print) GLADYS L. SII | 20 104 5 | 191 | b. MAILING | | | | | Route Number, City or Tox | | | |
| | | rim3 | <u> </u> | 701 | | | | RD. | BAUTO. | | | |
| | 20e. METHOD OF DISPOSITION 1 Aburiel 2 Cremetion 3 Remo | val from State | 20b. PLACE A cemetery, cre | AND DATE | OF DISPO | SITION (Ne | me of | | 9/6/91 B | OCATION C | City or Tov | wn, State |
| | 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE | ENGEE | PANK | woo | | | | | | | | -D. |
| | £ | n P. | | N . | | FUAL | US 4 | - BULN | CKAL CI | AAPE | L | |
| | Lugine | 1 Las | In | n | 8 | 1800 | HA | RFO | 20 20. | BALT | 0.2 | rg.5153A |
| | 23. PART I. Enter the diasases, or shock, or hasrt failurs. L | omplications that | caused the de | ath. Do i | not enter | r tha mo | da of dyi | ng, aucl | h aa cardisc or reap | olratory srn | eat, | Approximata interval Between |
| | IMMEDIATE CAUSE (Final | 1. | | | /. | 1 | 1 | 1 | | | | Onaat and Daeth |
| | disesse or condition resulting in death) | 1 JORNO | CACINOI | ns, | me to | 547. | 4,6 | inten. | own prim | 01 | | 4 months |
| - 1 | | DUE TO | (OR AS A CONSEC | QUENCÉ Ó | F): | | • | | / |) (| | - |
| ON | Sequentially list conditions, | DUE TO | 100 to 1 00110E | | _ | | | | | | | |
| ERTIFICATION | if any, lasding to immediate cause. Enter UNDERLYING | DOE 10 | (OR AS A CONSEC | OUENCE O | F): | | | | | | | |
| 5 | CAUSE (Disease or injury that initiated evants | DUE TO | (OR AS A CONSEC | QUENCE O | F): | | | | | | | |
| Ē | reaulting in death) LAST | | , | | . 1. | | | | | | | |
| B | d | | | | | | | | | | | |
| AL | PART II. Other significant conditions | contributing to | death but not r | resulting | in tha u | nderlying | g cause g | given in | Part i. 24a. WAS AI | | 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| MEDICAL | | | | | | | | | 1 YES | | | COMPLETION OF CAUSE OF DEATH? |
| ME | | | | | | | | | | | | 1 YES 2 NO |
| ä | | | | | | | | | | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | 07110 | | ACE OF D | EATH (Che | eck only one) | | | |
| YSI | 4 17 1100 4 17 16 | 1 Inpatient 2 | ER/Outpatient 3 | □ DOA | 4 Nu | | e 5 🗆 Re | sidence | 6 Other (Specify) | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 28e. DATE OF (Month, D | | 28b. TIM | E OF | 28c. INJ | URY AT RK? | | 28d. DESCRIBE HOW | INJURY OCC | UREO | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | | | | М | | rES 2 | NO | | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE O building, | F INJURY - At ho etc. (Specify) | me, ferm, | street, fec | tory, office | | | 28f. LOCATION (Street City or Town, State | and Number | or Rural A | oute Number, |
| <u> </u> | 4 Hornicae determined | | | | | | | | | | | |
| COMPLET | (Check only 1 CERTIFYING PHYSIC | IAN: To the best of | my knowledge, de | ath occurr | ed at the | time, date | end plece, | end due | to the ceuse(e) end me | nner ee state | ∍d. | |
| ON | One) 2 MEDICAL EXAMINER | : On the basis of s | emination end/or i | investigatio | on, In my | opinion, de | eath occur | ed at the | time, date end place, e | nd due to the | e ceuse(e) | end menner ee atsted. |
| BE C | 296. SIGNATURE AND TITLE OF CERTIFIER | CHOIS | | | | | 29c. LICE | NSE NUN | IBER | 29d. DATE | SIGNED | (Month, Day, Year) |
| 0 8 | / dam | L MO. | | | | | D3. | 271 | r3 | 1 9/ | 6/9. | 7 |
| | 30 NAME AND ADDRESS OF DEDSON WHO | | | | | - | | | | | 7_ | |

32. REGISTRAR'S SIGNATURE Sandan-Ra

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

7401

ADAMS

Dn. Joseph 31. DATE ENER MONTH 709 9994

DHMH-16 Rev 1/89

Tocuson MD. 21204

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OSLER Dr. Saite

36.

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should within the cours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Item with the course after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

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| BOX 68760 | executed |
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| OR | that |
| RECORDS, P.O. | requires |
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| TA | The |
| DIVISION OF VITAL | PHYSICIAN: |
| VISION | ATTENDING |
| 5 | OR A |
| | - |

| | FOR STATE REGISTRAR | F.H. FII | LM G-715 9/ STATE OF F | | | RTMEN' | T OF I | IEALTH | AND I | MENTA | L HYGIEN | E | | |
|----------------------|---|------------------------------|--|---------------------------------------|---|----------------------------|-------------|--------------|--------------------|------------------|----------------------------------|------------|----------------------------|---|
| | | | | | ERTIF | | | | | | REG. NO. | | | |
| | 1. DECEDENT'S NAME (First, | | | | | | | | | 2. DATE | OF DEATH | NY | YEAR | 3. TIME OF OEATH |
| 3 | Frederi | | Louis | | CHRAU | DNER | | | | Sep | tember | 6. 1 | 994 | 12:10P M |
| | 4. SOCIAL SECURITY 213 | | 05. SEX | 6. AGE (In yrs. 87 | lest birthday) YRS. | MONTHS | DAYS | HOURS | MIN. | 7. DATE | OF BIRTH | 1907 | Could | PLACE (State or Foreign |
| | 9e. FACILITY NAME (# not in | stitution, give s | treet and number) | | | | | OR LOCATI | | ATH | | 9c. COU | ITY OF D | EATH |
| 8 | Franklin | | spital | | | h | 0551 | rille | • | | | Bal | timo | ore |
| ᇈ | RESIDENCE OF DEC | 10b. COUNT | | | 40.00 | ry, town | | | | | | | | Carry |
| DIRECTOR | Maryland | | Baltimor | e | 100. 01 | IT, IOWN | Esse | | | | | | | 16d. INSIDE CITY LIMITS? 1 YES 2 NO |
| FUNERAL | 104. STREET AND NUMBER | illtop | Ave. | | | | 10 | 212 | | | | - | USA | WHAT COUNTRY? |
| B | 11, MARITAL STATUS 1 Never Merried 2 3 Widowed 4 Divo | | 12. WAS DECEOEN FORCES? 1 IF YES, GIVE V | YES 2 | ARMED CALO | | If yes, sp | | m, Mexica | n, Puarto | N? (Specify Yes Rican, etc.) | or No- | 14. RACI Blaci Speci | E — American Indian, k, Whita, etc. |
| COMPLETED | 15. OEC (Specify only Elementary/Secondary (0 | EDENT'S EDU highest grade | CATION completed) College (1-4 or 5 | | OECEDENT'S (Give kind of life. Do NOT u | work done ise retired.) | during mo | ost of worki | ing | 161 | b. KINO OF BU | iness/ind | | |
| M M | 7 | | | | Owner | y- Ok | era | COT. | | | | raver | 51 | |
| BE COI | 17. FATHER'S NAME (First, M. Louis | | chraudn | er | | | | | | | Middle, Maiden | | on | |
| TO B | Nellie F. Jo | | riend | | 1750 | ADDRES Hill | s (Street | Ave. | r or Rural I Ba | Route Num | nore, | D 21 | 221 | |
| | 20a, METHOD OF DISPOSITION 130 Buriet 2 Cremetto 4 Donetton 5 Other | n 3 🗆 Rem | oval from State | | EANDDATE | | | | 9 | 9/9/9 | 7E 20c. LO 94 Ba | cation — | city or To | own, State |
| 1 1 | 21. SIGNATURE OF FUNERA | L SERVICE LIC | CENSEE | 2 | / | 22 | NAME A | ND ADDRE | SS OF FA | CILITY | ral Hor | no DA | | |
| | 1 James | " TX | Sun | kem | k |] | 407 | East | tern | Ave | Bali | timor | e, N | D 21221 |
| | 23. PAPE I. Enter the di shock, or he IMMEDIATE CAUSE (Fir disease or condition resulting in death) | eart fallure. | a. 65 | OR AS A CONS | Coli | · M1 | the mo | ode of dy | ing, suc | hae car | diac or reap | ratory arr | est, | Approximate interval Between Onset and Death |
| CERTIFICATION | Sequentially list conditi if any, leading to imme- cause. Enter UNDERLYI CAUSE (Disease or inju- that initiated events resulting in death) LAS | diate | a CR | (OR AS A CONS | | | ulis | 1 | | | | | | |
| PHYSICIAN: MEDICAL C | PART ii. Other aignifica | nt condition | s contributing to | death but no | t reaulting | In the u | nderlyln | g cause | given in | Part I. | 24a. WAS AN PERFOR 1 YES 2 | | 24b | MERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| AN | 25. WAS CASE REFERRED TO | O MEDICAL | 1 | · · · · · · · · · · · · · · · · · · · | | | 28 D | ACE OF F | DEATH 10- | ack mak | (00) | | | |
| 1 2 | EXAMINER? | | HOSPITAL: | T EDIO. 1 | | OTHE | R: | LACE OF D | _ | | | | | |
| 1 | 27. MANNER OF OEATH | | 1 Inpatient 2 | | 3 L DOA | | _ | NO 5 AT | esidence | | er (Specify) SCRIBE HOW I | N IIIIN OO | TIDER | |
| BY PI | 1 Netural 5 | Pending Investigation | (Month, E | Day, Year) | IN | M | 1 🗆 | YES 2 | □ NO | | | | 1150 11 | |
| PLETED | | Could not be determined | 28e. PLACE C building | OF INJURY — At etc. (Specify) | home, term, | street, lac | tory, offic | | | 281. LOI City | CATION (Street or Town, Stete) | and Number | or Rural i | Route Number, |
| DWINE | onel | | ICIAN: To the best of a | | | | | | | | | | | s) end menner ea stated. |
| LO | 29b, SIGNATURE AND TITLE | | | | | | | | ENSE NUI | | | | | (Month, Day, Year) |
| 3 | | | Jul | | | | | 7 | 147 | 22 | (| DATE DATE | 9 | 7 · 9 c |
| T | 30. NAME AND ADDRESS OF | PERSON WH | 12 2 13 | SE OF DEATH (| TEM 27) (Typ | | -Tow | 21 | 221 | | | | / | |
| | SEP 0 7 19 | 94 | 32. REGISTRA | AR'S SIGNATURI | | | | - (| | | | | | |

And the second of the second o

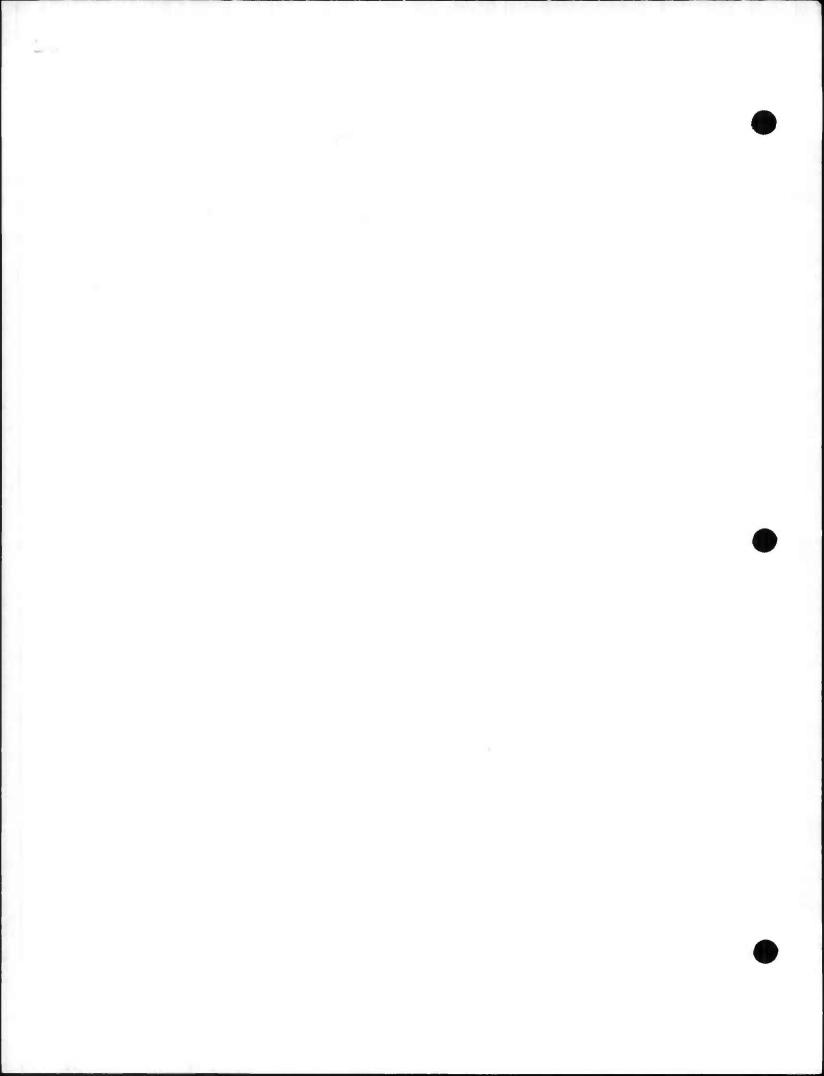
10.

lined by the hospital or attending physician. hould be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| TO THE HOSPITAL OF TEMBONG NYSICIAN: The law requires that the death certificate be executed with Australia ours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIFFECTOR TO BE SENDED TO BE SHOULD BE SHOULD BE SHOULD BE SHOULD BE SHOULD BE GREACHED BE SHOULD BE DESCRIBED BY THE STREET FOR THE STREET BY SHOULD BE DESCRIBED BY THE STREET BY THE STREET BY SHOULD BE DESCRIBED BY THE STREET BY THE STRE | IMPORTANT: If item we is moved, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|---|
| Jours aft | ation, or remo | the medica |
| be executed with | ian and complete | sumatic event, |
| ath certificate t | ttending physici al Hygiene pho | , or other tra |
| res that the de | igned by the a | rs any injury |
| The law requir | ate Dept. of H | em 23 show |
| I PAYSICIAN: | m certifica | pered, or It |
| H TENDING | of the obs | m sis m |
| TO THE HOSPITAL O | TO THE FUNERAL DIFFCO. The property free has been signed by the attending physician and completely filled in by the lost fleed within 72 hours. The committee of the State Dept. of Health and Mental Hydiene prior to burial, cremation, or removal. | IMPORTANT: If Ite |

| | FOR STATE REGISTRAR | STATE OF MARYL | | MENT OF HEA | | MENTAL HYGIEN | E | |
|---------------|---|---|-------------------------|---|------------------|---|---------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 0 | | 1 | 1- | 2. DATE OF DEATH MONTH DA | Y _ YEA | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (1) | In yrs. lest birthday) | CONSTUNDER 1 YEAR IN | UNDER 24 HRS. | 7. DATE OF BIRTH | 1 94 | 10 PM |
| | 180-03-5619 | 1 M 2 □ F 80 | -)4 P | RTNPLACE (State or Foreign buntry) Pennsylvania | | | | |
| DIRECTOR | 96. FACILITY NAME (If not institution, give street Harbor Hospital Co | | 9 | Baltimo | | ATN | Balti | |
| 3EC | 10a. STATE 10b. COUNTY | | 10c. CITY, T | OWN OR LOCATION | | | | 10d. INSIDE CITY |
| | Maryland Baltime | ore | I | ansdowne | | | 10a CITIZEN C | LIMITS? 1 YES 2 NO OF WHAT COUNTRY? |
| FUNERAL | 2425 Brunswick Ro | ad | | | 21227 | | | SA |
| S I | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN FORCES? 1 YES | | 13. WAS DECENO | ENT OF HISPAN | IC ORIGIN? (Specify Yee | or No - 14, R | ACE — American Indian, llack, White, etc. |
| BY | 1 Never Married 2 XXMerried 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DA | TES | 1 TES 2 | | | | pocity: white |
| LED | 15. DECEDENT'S EDUCA (Specify only highest grade or | TION ompleted) | 16a. DECEDENT'S US | UAL OCCUPATION done during most of | working | 16b. KIND OF BUS | I BINESS/INDUSTR | |
| Ē | | College (1-4 or 5+) | Ille. Do NOT use re | etired.) | working | | | |
| COMPLETED | 17. FATNER'S NAME (First, Middle, Last) | | Quality | | MOTNER'S NAI | ME (First, Middle, Maiden | anufact | uring |
| BE C | John Sadowski | | | | Lillia | | | |
| 10 B | 19e. INFORMANT'S NAME (Type/Print) | | | | umber or Rural R | loute Number, City or Town | n, State, Zip Code, |) |
| | Apolnia B. Sadows | | | Brunswic | | Lansdowne | | |
| | 1 Buriel 2 Cremation 3 Remov. | al from State cem | PLACE AND DATE OF C | plece) | | | CATION — City o | |
| | 21. BIGHATURE OF FUNERAL BERVICE LICEN | NSER! | Oudon Par | 22. NAME AND A | DORESS OF FAC | YTIJK | | , Maryland |
| | 0/05 | (4 | L. | | | cal Home of | | |
| | 23. BART I. Enter the diseeses, or con | mplicetione that ceused | the deeth. Do not | enter the mode | of dying, such | Ferry Roa | ratory srrest, | Approximete |
| 4 | ahock, pr heart fellure. Lis IMMEDIATE CAUSE (Final | R Dnly Dne cause Dn ea | ich line. | ~) | | | 11 | Interval Between Onset and Death |
| | disease or condition resulting in death) | DUE TO OPIAS A | CONSEQUENCE OF: | 9, 4120 | n1 (3) | sadyla | die | |
| _ | | mos lo | CONSEQUENCE OF !: | (P)en | 15/ | 112 | | |
| TIO | Sequentially list conditions, if sny, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF): | 10 1 | | | 1.)_ | |
| PIC | cause. Enter UNDERLYING CAUSE (Disease or Injury | DUE TO (OR AS A | CONSEQUENCE OF: | -18 184 | ndes | ocen-cur | Ble |) south |
| CERTIFICATION | that initisted events resulting in desth) LAST | 702 10 (oil 10 X | oonscooling or j. | V | | LUNG | | |
| | PART II. Other algoliticent conditions | contributing to deeth by | ut not regulting in t | he underlying co | tite alven in i | Part I. 24a. WAS AN | Aumeey | 24b. WERE AUTOPSY FINDINGS |
| ICAL | | | at not revening in | are directlying co | use given iii | PERFOR | MED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDIC | | | | | | 1 YES 2 | KNO | OF DEATH? |
| | DID TOBACCO USE CO | ONTRIBUTE TO | CAUSE OF I | DEATH YES | □ NO | | | 3,10 |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: 2 | 0 | 26. PLACE | OF DEATN (Che | ck only one) | | |
| 14S | 1 YES 2 NO 1 | 28e. DATE OF INJURY | atient 3 DOA 4 | Nursing Nome 5 | | 6 Other (Specify) 28d. DESCRIBE NOW II | I III OOO IDEE | |
| | 1 Netural 5 Pending | (Month, Day, Year) | INJUR | Y WORK? | 2 NO | 200. DESCRIBE NOW II | AJORY OCCURE | · |
| TED BY | 2 Accident investigation 3 Suicide 8 Could not be 4 Homicide detarmined | 28e. PLACE OF INJURY building, etc. (Special | — At home, ferm, atre | et, factory, office | | 281. LOCATION (Street e City or Town, Stete) | nd Number of Ru | ral Route Number, |
| COMPLETED | 29a. CERTIFIER 1 CERTIFYING PHYSICIA | AN: To the best of my knowle | adds death occurred a | at the time date and | place, and due | to the country and man | | |
| OMP | | On the basis of exemination | | | | | | se(a) end manner as stated. |
| u l | SIGNATURE AND TITLE OF CERTIFIER | 0 100 | ·~1 | | LICENSE NUM | | | YED (Mghth, Day, Year) |
| TO B | Wusell (| J 4 127 | ~ / | | 1)3) | 55) | ▶ 9/ | 1/94 |
| | 30 NAME AND ADDRESS OF PERSON WHO | CULLY NO. | TH (ITEM 27) (Type, Pri | 5. Nano | VTC S | + Ball | mest | 2/2025 |
| | 31. DAY ELP (101/707994 | 32. REGISTMAR'S SIGNA | | 70 | | · I VIP | | |
| | - // | | and as II | | | | | 1 |

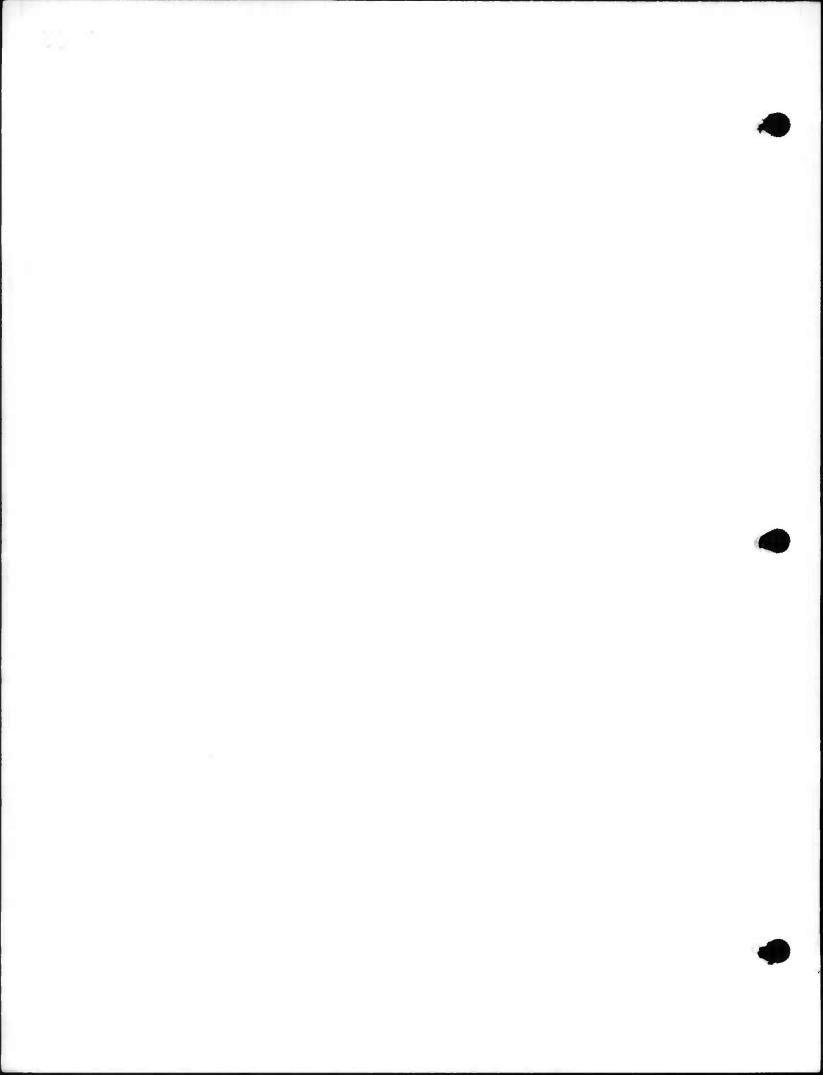


After this certificate has been signed by the attending physician and completely initial in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detach with the State Dept. of Health and Mental Hydlene prior to burial, cremation, or removal. urs after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21203-3146 ENDING PHYSICIAN: The law requires that the death certificate be executed within DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPI TO THE FLINE De filed with IMPORTANT

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I | MENTAL HYGIENE |
|--|----------------|
| CERTIFICATE OF DEATH | REG. NO. |

| | FOR 1 - STATE REGISTRAR | STATE OF MAR | | NT OF HEALTH AND | MENTAL HYGIENE REG. NO. | | | | | |
|------------------|---|--|--|---|--|-------------------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, M | liddle, Last) | 02 | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | |
| | (Sister) M | ary David Sma | llwood, OS | P | 09-05-9 | 4 | 4:00a.M. | | | |
| | 4. SOCIAL SECURITY NUMBER | | GE (In yrs. lest birthday) IF UI | NDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTH | IPLACE (State or Foreign | | | |
| | 220-56-890 | 8 1 □ M 2 ★□ ¥F | 90 YRS. MONT | HE DAYS HOURS MIN. | 06-21-0 | | shington, DC | | | |
| | 90. FACILITY NAME (If not instit | ution, give street and number) | 9b. (| CITY, TOWN OR LOCATION OF D | EATH 9 | c. COUNTY OF D | | | | |
| FUNERAL DIRECTOR | Oblate Sis | ters of Provi | dence (HCU | () Catonsv | ille | Bal | timore | | | |
| E | 10a. STATE 1 | Ob. COUNTY | 10c. CITY, TOV | VN OR LOCATION | | | 10d. INSIDE CITY LIMITS? | | | |
| 5 | MD | Baltimore | Cato | nsville | | | 1 TYES 2 NO | | | |
| ₹ I | 10e. STREET AND NUMBER | | | 101. ZIP CODE | 12 | 0g. CITIZEN OF 1 | WHAT COUNTRY? | | | |
| ij. | 701 Gun Ro | | | 21227-3 | | USA | | | | |
| 5 | 11. MARITAL STATUS 1 Never Merried 2 Merried 2 Merried Description | 12. WAS DECEDENT EV FORCES? 1 1 | rES 2 KNO | 13. WAS DECENDENT OF HISPA If yes, specify Cuban, Mexico | an, Puerto Rican, etc.) | Blac | E — American Indian, k, White, etc. | | | |
| BY | 3 Widowed 4 Divorce | IF YES, GIVE WAR | OR DATES | 1 YES 2 NO Specif | y: | Afr | ican America | | | |
| | | DENT'S EDUCATION | 16a. DECEOENT'S USUA | L OCCUPATION | 16b. KIND OF BUSIN | | TOUR TRICETOR | | | |
| Ē | (Specify only h Elementary/Secondary (0-12 | 2) College (1-4 or 5+) | (Give kind of work d life. Do NOT usa retin | one during most of working ed.) | | | | | | |
| 필 | | | Teacher | | | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Midd | lle, Lest) | | 18. MOTHER'S NA | AME (First, Middle, Maiden Sur | mame) | | | | |
| BE (| Alfred Sma. | | | Mary | Jane But | ler | | | | |
| 5 | 19e. INFORMANT'S NAME (Type | | | RESS (Street end Number or Rural | | | | | | |
| - | | Alexis Fisher | | Gun Road | | | 21227-3899 | | | |
| | 20a METHOD OF OISPOSITION 1 Description | 3 Removal from State | other place) | (Name of cemetery, crematory or | | TION — City or To | | | | |
| | 4 Oonation 5 Other (S | ,,, | Loudon Pa | rk Cemetery | | timore | , MD | | | |
| | | 1. (M) | , | March F/H W | | | | | | |
| | 1/00 | a Than | ch | 4300 Wabash | Avenue 1 | | ore, MD 2121 | | | |
| | | nasea, or complications that ca art feliure. List only one cause | | nter the mode of dying, eu | ch as cerdisc or respirat | Dry arrest, | Approximate Interval Between | | | |
| | IMMEDIATE CAUSE (Final | | 0010 | , | | | Onset and Death | | | |
| | disease or condition reaulting in death) | • <u>D</u> | 1012 | | | | 1 day | | | |
| | INFECTED DECUBITUS VLCER 2 mo | | | | | | | | | |
| NO | Sequentially list condition | na, b. J. N. T. | AS A CONSEQUENCE OF: | DELUB | 11/0/5 | VLCE | Zmo | | | |
| Ĭ. | If any, leading to immediata cause. Entar UNDERLYING | | | | | | | | | |
| 임 | CAUSE (Disease or Injury that initiated events | , c | AS A CONSEQUENCE OF): | | | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | |
| | DAST II Other simultiness | and the same and t | Ab b | | | | | | | |
| MEDICAL | PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY PERFORMED? PERFORMED? COMPLETION DE CAUSE | | | | | | | | | |
| ŏ | + 600 | The state of the s | 1051 -1 | | 1 TYES 2 | NO | OF DEATH? | | | |
| M | 1 YES 2 NO | | | | | | | | | |
| A | AT WAS CASE DEFENDED TO | MEDICAL | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | | | | | | | | |
| 17S | 27. MANNER OF DEATH | 28a. DATE OF INJ | | Nursing Home 5 Residence 28c. INJURY AT | 28d. DESCRIBE HOW INJ | | Krinky | | | |
| | 1 Natural 5 P | ending (Month, Day, Y | | WORK? M 1 YES 2 NO | 280. DESCRIBE NOW INC. | ONI OCCONED | 1 | | | |
| BY | 2 Destate | vestigation 28e. PLACE OF IN | JURY — At home, ferm, street | | 28f. LOCATION (Street and | Number or Rural | Route Number | | | |
| E | 3 Suicide S Could not be determined Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, ferm, street, factory, office City or Yown, State) | | | | | | | | | |
| | 290. CERTIFIER | EVING DUVERGIAN. To the heat of my | Immulados danth assumed at | the time of the end of the end of | | | | | | |
| COMPLETED | (Oridon Oriny | FYING PHYSICIAN: To the bast of my AL EXAMINER: On the basic of exami | | | | | e) and manner as stated. | | | |
| | 29s. SIGMATURE AND TUPLE O | | | 29c, LICENSE NU | | | 0 (Month, Day, Year) | | | |
| BE | Sula | aras - | NO | 7) 9 / | 649 | ▶ 9 - 1 | 94 | | | |
| 5 | 730. NAME AND ADDRESS OF I | PERSON WHO COMPLETED CAUSE OF | F DEATH (ITEM 27) (Type, Print | - WILKE | VS AVE | RAIT | Mn 11229 | | | |
| | | | | J 101-100 | 5 11.1 | 71-11 | 10212 | | | |
| | SEP 0 7 199 | 4 Juli Senden | Renderl | | | | 1 | | | |



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| BALTIMORE, MARYLAND 21215 | Aure after death. Page 6 may he natained by the hospital or attended |
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COMPL

BE

2

2 Accident

4 Homicide

SEP 0 7 1994

8 Could not be

determined

3 Suicide

| HYSICIAN: The law requires that the death certificate be executed within Jours after death. Page 6 may be retained by the hospital or attending physician. | this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | ion, or removal. | he medical examiner must be notified at once. |
|--|--|--|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

94 26134 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR JOHN SALADIS Sept. 1994 4. SOCIAL SECURITY NUMBER 5. SEY 7. DATE OF BIRTH
(Month, Day, Year)
July 29,1912 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 82 DAYS 472-05-8906 1 X M 2 | F YRS. Wisconsin 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 41 Township Rd Dunda1k Baltimore RESIDENCE OF DECEDENT 10a. STATE 10c, CITY, TOWN OR LOCATION 10d, INSIDE CITY Md. Baltimore Dundalk 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 41 Township Rd 21222 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, alc. If yea, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: FORCES? 1 YES 2 NO 1 Never Married 2 Married ВУ Specify: White 3 🕅 Widowed 4 🗌 Divorced COMPLETED 15. DECEOENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) 12 Ford Motor Co. Mechanic 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname, Dominic Saladis Emily Yarmalovich BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 41 Township Rd. Dundalk, Md 21222 Pat Hasty 20a. METHOO OF DISPOSITION
1 X Burlel 2 Cremellon 3 Removal from Stale
4 Donallon 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, Slate 9/8 Remetery, commutory or other place)
Washington Mem Park Seattle, Wa. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY olt Connelly Funeral Home of Dundalk 7110 Sollers Pt Rd. 21222 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feliure. List only one ceuse of each line. Approximate Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition_ reculting in deeth) of right log CERTIFICATION Sequentially list conditione, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO X PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inputient 2 | ER/Oulpetient 3 | DOA OTHER: 1 YES ZY NO 4 - Nursing Homa SX Residence 6 - Other (Specify) 27. MANNER OF GEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED Natural 5 Pending Investigation м

1 YES 2 NO 28e. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State)

Balt., Md. 21222

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one)

2 MEDICAL EXAMINER: On the basis of a ation and/or investigation, in my opinion, death occured at the lime, data and placa, and due to the cause(a) and manner as stated.

30. NAME AND ADDRESS OF PERSON WHO O ED CADSE OF OEATH (ITEM 27) (Type, Print)

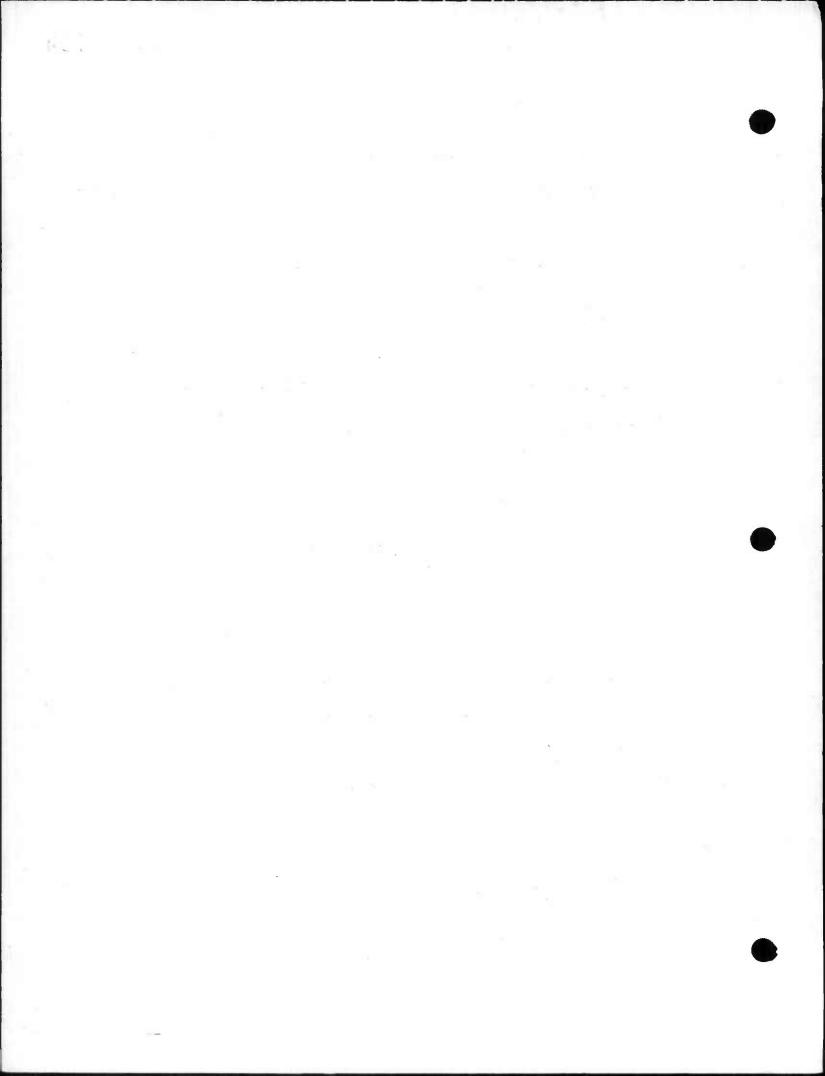
16

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year)

Yukna M.D. Bernard J. 59 Dundalk Ave

32. PEGISTRAR'S SI NATURE



BALTIMORE, MARYLAND 21215-0020

S, P.O. BOX 68760,

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ATTENDING PRINCIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should until me state Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. TO THE HOSPITAL OF TO THE FUNERAL FOR SIGHT WITHIN 72 IMPORTANT, If IMPORTANT, IF

bried, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | | EKITE | CATE (|)F DEA | TH | F | EG. NO. | | | |
|------------------|--|--------------------------------|--|----------------|---|---------------|--------------------------|-----------------|--|--------------|-------------|-----------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF | DEATN | | YEAR | 3. TIME OF DEATN |
| - 1 | Frances A | . Seibert | | | | | | Sept. | | , 19 | | 12:45 A. M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. Is | ast birthday) | IF UNDER 1 YE | _ | R 24 HRS. | 7. DATE OF I | HETN | | 8. BIRTHP | PLACE (State or Foreign |
| 12 | 216-20-3438-A | 1 M 2 XXF | 88 | YRS. | MONTHS DA | rs HOURS | MIN. | Dec. 1 | | 0.5 | Mary | , land |
| | 9a. FACILITY NAME (If not institution, give s | street and number) | | | 9b. CITY, TO | VN OR LOCAT | | | . 0 , 1) | | NTY OF DE | |
| E I | St. Joseph Hos | spital | | - 1 | | Towson | 1 | | | B | altin | nore |
| 5 | RESIDENCE OF DECEDENT | | | | | 10,000 | | _ | | | are in | |
| Ä | 10e. STATE 10b. COUNT | Y | | 10c. CITY | , TOWN OR L | CATION | | | | | | 10d. INSIDE CITY LIMITS? |
| <u> </u> | Maryland B | Baltimore | | | Ва | ltimon | re | | | | | 1 YES 2 NO |
| 4 | 10e. STREET AND NUMBER | | | | | 10f. ZIP COL | DE | | | 10g. CITI | ZEN OF WI | HAT COUNTRY? |
| FUNERAL DIRECTOR | 9619 Dundawan R | Road | | 21236 | | | | | U | .S.A. | | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT | EVER IN U.S. A | RMED | 13. WAS | DECENDENT | OF HISPANIC | C ORIGIN? (S | pecify Yea | or No- | 14. RACE | - American Indian, White, etc. |
| BYF | 1 Never Married 2 Married | FORCES? 1 [IF YES, GIVE WA | | INO | If yes | yes 2 X NO | an, Maxicen, Specify: | , Puerto Ricar | ı, atc.) | | Specify | White, etc. |
| | 3 X Widowed 4 Divorced | | | | | | | | | | | White |
| | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | (| Give kind of w | DENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTR | | | | | | USTRY | |
| W | Elementary/Secondary (0-12) | College (1-4 or 5+) | | fe. Do NOT us | e retired.) | | | | | | | |
| ₹ | N/A | N/A | | Secr | etary | | | Pı | Publishing Company | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | E (First, Middl | | , | | |
| BE | William Green | | | | | | | eth M | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | ADDRESS (Str | | | | | | Code) | |
| - 1 | Mrs. Alice Maffe | | :) | 9619 | Dunda | wan Ro | oad, l | Baltin | ore, | MD | 2123 | 36 |
| | 20a, METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Ram | owel from State | 20b. PLACE | AND DATE O | F DISPOSITIO | (Neme of | | DATE | | | City or Tow | , |
| ļ | 4 Donation 5 Other (Specify) | | More | land N | herplace) Temori | al Par | ·k | 9/8 | Bal | timo | re, M | laryland |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | CENSEE | | | 22. NAM | imunel | ESS OF FACI | LITY | Iomos | To | | |
| | 1/1/1/1/ | | | | 1 | | | | | | | 21226 |
| | 23. PART I. Enter the diseases, or | complications that | coursed the d | leeth Do o | | 5 Bela | | | | | | |
| | shock, or heart fellure. | List only one ceus | e on each lin | ie. | or enter the | mode or dy | mg, such | aa cardiec | or reapi | ratory arr | eat, | Approximate interval Between |
| Н | iMMEDIATE CAUSE (Final disease or condition | | , | 01 | | 1 | 10. | 0 - | | | | Onset and Desth |
| | resulting in death) | a | | ora | roc C | Upr | vaca | a | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| F | If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | |
| 윤 | CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| E | resulting In death) LAST | | | | | | | | | | | |
| 8 | d | | | | | | | | | | | |
| 7 | PART ii. Other significent condition | ns contributing to d | deeth but not | resulting in | n the under | ying ceuse | given in P | art I. 24s | . WAS AN | | | WERE AUTOPSY FINDINGS |
| EDICAL | | | | | 11 | PERFOR | . 4 | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | |
| | | | | | | | | _ '' | 100 % | at no | | OF DEATN? |
| Σ | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | | | | | | |
| ₹ I | 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) | | | | | | | | | | | |
| PHYSICIAN: | EXAMINER? HOSPITAL: OTHER: | | | | | | | | | | | |
| Ĭ | 27. MANNER OF DEATH 28a. DATE OF INJURY | | | | | | | | | I II IDV OCC | TIBED | |
| | Netural 5 Pending (Month, Day, Year) INJURY WORK? | | | | | | | | | | | |
| À | 2 Accident Investigation 20 PLACE OF INVIEW | | | | | | | 201 LOCATIO | M (Otmat o | and Managhan | | |
| | 3 Suicide 8 Could not be detarmined 28a. PLACE OF INJURY — At home, farm, etreet, fectory, office building, atc. (Specify) 28a. PLACE OF INJURY — At home, farm, etreet, fectory, office City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| <u>u</u> | 29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) end menner as stated. | | | | | | | | | | | |
| P | (Check only | | | | | | | | | | | |
| COMPLET | 2 MEDICAL EXAMINE | ER: On the beels of exa | mination and/or | investigation | n, in my opinic | n, death occu | ired at the ti | me, date end | place, end | d due 10 th | e cause(a) | end menner ae stated, |
| w II | 296. SIGNATURE AND THE OF CERTIFIE | R 011 | | | | 29c. LIC | ENSE NUMB | DER | | 29d. DATE | SIGNED (| Month, Day, Year) |
| 0 | Jeggo- | corlu | | | | | 120 | 1650 |) | • | 7-6 | 74 |
| 유 | 30. NAME AND ADDRESS OF PRASON WN | | | | | | 77 | | | | | |
| | Dr. Jeffrey A. C | Cool, 9 712 | 2 Belai | r Rd. | , Balt | imore | , MD | 21236 | 5 | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR | 'S SIGNATURE | | | | | | | | | |
| | SEP 0 7 1994 | This Serie | | | | | | | | | | |
| | | The state of the state of | Secretary of the last of the l | | | | | | | | | |

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Thus after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | NT OF HEALTH AN | | | | | |
|------------------|--|--|--------------------|---|----------------------------|--------------|--|--|--|
| | | Taylor Spilma | | | 2. DATE OF DEAT | | 3. TIME OF DEATH 1:31 p.m.m | | |
| | 4. SOCIAL SECURITY NUMBER 218-34-2181 | 1 M 2 M F 7 | 9 YRS. MONT | | Mar. 12 | , 1915 M | eryland | | |
| TOR | Sinai Hospital RESIDENCE OF DECEDENT | street and number) | 9b. 0 | Baltimore | OF DEATH | 9c. COUNTY C | OF DEATH | | |
| DIRECTOR | 10a. STATE 10b. COUN | ltimore | 10e. CITY, TOW | Owings Mil | lls | | 10d. INSIDE CITY LIMITS? 1 YES 2 1 NO | | |
| FUNERAL | 104 STREET AND NUMBER 517 Garrison | n Forest Rd. | | 101. ZIP CODE 21] | 17 | | OF WHAT COUNTRY? | | |
| ВУ | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER I FORCES? 1 TYES IF YES, GIVE WAR OR D | 2 X NO | 13. WAS DECENDENT OF H If yes, specify Cuban, N 1 YES 2 NO | lexican, Puerto Rican, etc | .) | or No- 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| COMPLETED | 15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12) | completed) College (1-4 or 5+) | | one during most of working ad.) | | memaker | RY | | |
| | 12 17. FATHER'S NAME (First, Middle, Lest) William V | Winchester Wh | Housev ite | 18. MOTHER | 'S NAME (First, Middle, Me | | ing | | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) John A. Spilman | n IV | | ess (Street and Number or I | | | | | |
| | John A. Spilman IV 1505 Broadway Rd., Lutherville, Md. 21093 20e, METHOD OF DISPOSITION 1 QBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cem. Sept. 7, 1994 Pikesville, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, interval onset a disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | С. | A CONSEQUENCE OF): | | | | | | |
| AL | PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 246. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF 1 | | | | | | | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? NOSPITAL: OTHER: | | | | | | | | |
| BY PHYS | 1 | | | | | | | | |
| | 2 Nockdent Investigation 3 Suicide 6 Could not be determined 266. PLACE OF INJURY - At home, farm, street, factory, office 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION (St | | | | | | | | |
| COMPLETED | one) | SICIAN: To the best of my know IER: On the basis of examination | | | | | use(a) and manner ea stated, | | |
| TO BE C | 29b. SIGNATURE AND TITLE OF CERTIFIED | eurs. MI | 2 | 29c. LICENS | ENUMBER 32/BL98 | | pt. 4, 1994 | | |
| | 30. NAME AND ADDRESS OF PERSON W Barry L 31. DATE FYCED/Mooths Day Abox | | +35 W. ! | | | | in Mdzizis | | |
| | SEP 0 7 1994 | Juli Danisan- | | | | | | | |

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the Towns after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR | STATE OF MARYL | CERTIFICA | | | | EG. NO. | |
|---|--|--|---|------------------------------------|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, I. Hele | en B. Simmerlin | | | | 2. DATE OF C | | year 3. TIME OF DEATH 12:30 p |
| 4. SOCIAL SECURITY NUMBER 388=05=2333 | 1 🗆 M 2 🖄 F | S " | | IF UNDER 24 HRS. | 7. DATE OF B (Month, Day June 7 | | a. BIRTHPLACE (State or Foreign Country) Michigan |
| 9a. FACILITY NAME (If not institution, g 308 Highfs | alcon Rd. | 9b. | Reiste | erstown | EATN | 9c. COU | altimore |
| 10a. STATE 10b. CO | | | own on Location istersto | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO |
| 100. STREET AND NUMBER 308 I | Highfalcon Rd. | costs | 10f, Z | IP CODE 21136 | | ZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D | 2 X NO | If yes, specif | DENT OF NISPAN fy Cuben, Mexice | in, Puerto Rican | pecify Yea or No- | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S (Specify only highest : Elementary/Secondary (0-12) | EDUCATION grade completed) College (1-4 or 5+) | 16a. DECEDENT'S USU (Give kind of work life. Do NOT use ret Housewii | done during most of tired.) | of working | | of Business/IND | |
| 17. FATHER'S NAME (First, Middle, Last John Pazde | * | | 1 | | ME (First, Middle y Cresi | , Meiden Surneme) .K | |
| 19a. INFORMANT'S NAME (Type/Print) Raymond J. S. | Simmerling | 196. MAILING ADD | DRESS (Street and Highfald | Number or Bural I | Reist | ily or Town, State, Zip Cerstown, | ^{co} Ma. 21136 |
| 20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 4 Donation 5 Other (Specify) | Removal from State CBI | b. PLACE AND DATE OF DI metery, crematory or other p | placel | | OATE | 20c. LOCATION — | |
| 21. SIGNATURE OF FUNERAL SERVICE | | Evergreen l | 22. NAME AND Eou ha | ADDRESS OF FA | CHITY | | 21117 |
| 23. PART i. Enter the diseases, | , or complications that cause | d the death. Do not a | | Reist | erstown | Rd., Ow | |
| 23. PART i. Enter the diseases, shock, or heart fall iMMEDIATE CAUSE (Final disease or condition resulting in death) | a. Atheros | each iine. | anter the mode | Reisto | erstown | or respiratory arr | eat, Approximata interval Between |
| iMMEDIATE CAUSE (Final disease or condition | a. DUE TO (OR AS | laco fic | anter the mode | Reisto | erstown | or respiratory arr | eat, Approximata interval Between |
| ahock, or heart fall iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | a. Due to (or as de de de de de de de de de de de de de | A CONSEQUENCE OF): A CONSEQUENCE OF): | Corar | Reisto | erstown h as cardiac Las cardiac | or respiratory arr | est, Approximate interval Betwee Onset and Deal |
| shock, or heart fall iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant cond | a. Due to (or as de de de de de de de de de de de de de | A CONSEQUENCE OF): A CONSEQUENCE OF): | Corar | Reisto | erstown h as cardiac Las cardiac | Rd., Own | Approximate interval Betwee Onset and Dear Onset an |
| shock, or heart fall iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant cond Other algnificant cond EXAMINER? | a. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS HOSPITAL: | A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF): but not reaulting in the | he undarlying of the undarlying of the the the the the the the the the the | Reiston of dying, auc | Part i. 24a | Rde, Own or respiratory are larger to the l | 24b. WERE AUTOPSY FINDING AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| ahock, or heart fall iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant cond Other algnificant cond 25. WAS CASE REFERRED TO MEDICE EXAMINER? 1 YES 2 NO 27. MANNIER OF DEATH 1 Natural 5 Pending | a. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS L. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS L. DUE TO (OR AS DUE | A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF): but not reaulting in the | anter the mode 26. PLAC THER: Nursing Nome 7. 28c. INJUR WORK | Reiste | Part i. 24e | Rde, Own or respiratory are larger to the l | 24b. WERE AUTOPSY FINDING AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| shock, or heart fall iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant cond Of the sequential cond I gray the sequents PART II. Other algnificant cond I gray the sequents 25. WAS CASE REFERRED TO MEDICE EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | a. OUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS L. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS L. DUE TO (OR AS DUE TO (OR AS L. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS L. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS L. DUE TO (OR AS | A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF): but not resulting in the partient 3 □ DOA 4 □ 26b. TIME OF INJURY Y — At home, term, stree. | anter the mode 26. PLAC THER: Nursing Nome 7 28c. INJUR M 1 YES | Reister of dying, auc | Part i. 24a 1 C Speck only one) 6 Other (Speck DESCRIE) | WAS AN AUTOPSY PERFORMED? YES 2 NO | interval Betwee Onset and Deal Onset and Deal 24b. WERE AUTOPSY FINDING: AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| ahock, or heart fall iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant cond 25. WAS CASE REFERRED TO MEDICE EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could no detarmine 29a. CERTIFIER (Check only | a. OUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS L. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS L. DUE TO (OR AS DUE TO (OR AS L. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS L. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS L. DUE TO (OR AS | A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF): Dut not resulting in the partient 3 DOA 4 DOA 1 | anter the mode 26. PLAC THER: Nursing Nome F | Reister of dying, auc | Part i. 24a 1 [26d. DESCRIE 26t. LOCATIO City or for | WAS AN AUTOPSY PERFORMED? YES 2 NO N (Street and Number with, State) | 24b. WERE AUTOPSY FINDING AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO DURED Or Rural Route Number, |
| ahock, or heart fall iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant cond 25. WAS CASE REFERRED TO MEDICE EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could no detarmine 29a. CERTIFIER (Check only | AL HOSPITAL: 1 General and the best of my known and market. On the best of examination of the best of axamination of the best of | path line. A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF): Dut not resulting in the path of the consequence of the | anter the mode 26. PLAC THER: Nursing Nome F VORK 1 YES RI, factory, office It the time, data and my opinion, deat | Reister of dying, auc | Part i. 24e Part i. 24e 1 [Deck only one) 26d. DESCRIE 28t. LOCATIO City or for to the cause(a) time, date and | WAS AN AUTOPSY PERFORMED? YES 2 NO N (Street and Number win, State) and manner se state place, and due to the | 24b. WERE AUTOPSY FINDING AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO DURED Or Rural Route Number, |
| ahock, or heart fall iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant cond | a. DUE TO (OR AS DUE TO (OR | path line. A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF): Dut not resulting in the path of the consequence of the | anter the mode 26. PLAC THER: Nursing Nome F VORK 1 YES RI, factory, office It the time, data and my opinion, deat | Reister of dying, auc | Part i. 24e Part i. 24e 1 [Deck only one) 26d. DESCRIE 28t. LOCATIO City or for to the cause(a) time, date and | Rde , Other or reapiratory are considered to the construction of t | 24b. WERE AUTOPSY FINDING AMAIL ABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO DURED Or Rural Route Number, ed. e cause(s) and manner as stated. E SIGNED (Worth, Dyr, Year) |

..... 5 U Haid

TO BE CO!

| the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans. Mental Hyglene prior to burial, cremation, or removal. Injury, or other traumatic event, the medical examiner must be notified at once. | nd completely filled in the burial. cremation, or restic event, the mediation | sit permit. Pages 1, 2, 3 should | | |
|---|--|-------------------------------------|-----------------------------|---------------------------|
| Jing physician and completely filled in I lygiene prior to burfal. cremation, or re- other traumatic event, the med | cate has been signed by the attending physician and completely filled in Is tate Dept. of Health and Mental Hyglene prior to burial, cremation, or re- Item 23 shows any Injury, or other traumatic event, the med | detached for use as the burial-tran | | once. |
| Jing physician and completely filled in I lygiene prior to burfal. cremation, or re- other traumatic event, the med | cate has been signed by the attending physician and completely filled in Is tate Dept. of Health and Mental Hyglene prior to burial, cremation, or re- Item 23 shows any Injury, or other traumatic event, the med | neral director, page 5 should be | | miner must be notified at |
| ding physician and lygiene prior to bu other traumati | cate has been signed by the attending physician and itate Dept. of Health and Mental Hygiene prior to but Item 23 shows any Injury, or other traumati | pletely filled in I | lal. cremation, or removal. | event, the medical exa |
| | rificate has been signed by ne State Dept. of Health and or Item 23 shows any I | the attending physician and | Mental Hygiene prior to bur | 8 |

| | FOR STATE REGISTRAR | STATE OF MARYLA | | TMENT OF I | | MENTAL HYGIEN | _ | | | |
|------------------|--|-------------------------------|--|--|--|--|------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | Edward C. | | | | 2. DATE OF DEATH MONTH DA | | 3. TIME OF DEATH | | |
| | 7.5- | | yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8.1 | BIRTHPLACE (State or Foreign Country) | | |
| | 217 40 4037 | 1 M 2 □ F 50 |) YRS. | | | 12/24/19 | | Maryland | | |
| œ | 9a. FACILITY NAME (If not institution, give street 450 Burbank Cou | | | Lansdo | OR LOCATION OF D | EATH | 9c. COUNTY | imore County | | |
| 5 | RESIDENCE OF DECEDENT | | | Danisdo | WIIC | | Dait. | inole country | | |
| DIRECTOR | Marginard 10b. COUNTY | imana Garanta | | , TOWN OR LOCA | TION | - | | 10d. INSIDE CITY LIMITS? | | |
| | Maryland Balt | imore County | Y La | ınsdowne | | | , | t 🗌 YES 2 🔀 NO | | |
| RA | 450 Burbank Cour | · + | | 10 | 21227 | | | OF WHAT COUNTRY? | | |
| FUNERAL | | 2. WAS DECEDENT EVER IN | U.S. ARMED | 13. WAS DEC | | NIC ORIGIN? (Specify Yes | | RACE — American Indian, | | |
| BY F | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 YES | | If yes, sp | ecify Cuban, Mexico | an, Puerlo Rican, etc.) | 9 | Black, White, atc. Specify: | | |
| | | - | | | | | | White | | |
| COMPLETED | 15. DECEDENT'S EDUCAT (Specify only highest grade con | npleted) | 16a. DECEDENT'S (Give kind of w life. Do NOT us | USUAL OCCUPATI vork done during me e retired.) | ON ast of working | 16b. KIND OF BUS | SINESS/INDUST | RY | | |
| P | Elementary/Secondary (0-12) (| College (1-4 or 5+) | Mainte | | | Leade | r Compa | anv | | |
| Ö | 17. FATHER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S NA | AME (First, Middle, Malden | - | 2 | | |
| BE C | Ed | ward C. Simo | ons Sr. | _ | He | len Tinley | | | | |
| 10 | 19a. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or Town | | | | |
| | Algene Simons 200. METHOD OF DISPOSITION | | | urbank (| | Lansdowne, | | | | |
| | 1 Sturiel 2 Cremation 3 Remova 4 Donation 5 Other (Specify) | I from State come | TERRETOR OF A STATE OF | PER DISPOSITION (N. her place) | IAL PARK | 8/31 G1 | CATION — City | or Town, State nie, Maryland | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | | CELL TIMVE | 22. NAME A | D ADDRESS OF FA | CILITY | - | | | |
| | Decome_ In | ramerow | alu- | _ | | nce Funeral | | | | |
| | 23. PART i. Enter the diseeses or com | nplications that caused t | the deeth. Do n | ot enter the mo | de of dying, suc | Hwy. Balt | THOLE, | Approximata | | |
| | shock, or heart failure. Lis immediate cause (Finel | only one cause on each | ch line. | | 1 1 | Annent | tota | Interval Between Onset and Death | | |
| | resulting in deeth) - a. 7/94 | | | | | | | | | |
| | | DUE TO (OR AS A C | CONSEQUENCE OF |): | Ulm | Known | oniw | 274 | | |
| ON O | Sequentielly list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| CAT | couse. Enter UNDERLYING he patic feelure ducto progression | | | | | | | | | |
| Ē | that initiated evente resulting in death) LAST | | | | | | | | | |
| CERTIFICATION | d | | | | | | | | | |
| AL C | PART ii. Other aignificant conditions of | ontributing to death but | t not recuiting i | n the underlyin | g ceuse given in | | | 24b. WERE AUTOPSY FINDINGS | | |
| | PERFORMED? AMAILABLE PRIOR TO 1 YES 2 NO COMPLETION OF CAUSE OF DEATH? | | | | | | | | | |
| ME | 1 _ YES 2 _ ND | | | | | | | | | |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | | |
| Sici | EXAMINER? | OSPITAL: | | OTHER: | 1 | D_ 1970 U.P.S | | | | |
| HX | 27. MANGER OF DEATH | 28e. DATE OF INJURY | 28b. TIME | | URY AT | 6 Other (Specify) 26d. DESCRIBE HOW II | JURY OCCURE | ED . | | |
| ВУ Р | 1 Netural 5 Pending (Month, Dey, Year) INJURY 2 Accident Investigation | | | | 1 VES 2 NO | | | | | |
| | 3 Suicide 6 Could not be | treet, factory, offic | | | TION (Street and Number or Rural Route Number, Town, State) | | | | | |
| ETE | 4 Homicide determined | building, atc. (Specify | | | | Only of form, charty | _ | | | |
| COMPLETED | | N: To the best of my knowled | | | | | | | | |
| CON | 2° MEDICAL EXAMINER: 0 | in the basis of examination a | and/or investigation | n, in my opinion, d | eath occured at the | time, date and place, and | d due to the car | use(a) and menner as stated. | | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | padd | 0 | | 29c. LICENSE NUI | MBER 11 1 | 29d. DATE SIG | NED (Month, Day, Year) | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO CO | OMPLETED CAUSE OF DEAT | H (ITEM 27) (Type | Print) | U 5 | 2-10-1 | 0 | 30,74 | | |
| | G. NIMMAGA | DDA HAI | CBOR - | HUSPI | AL CES | MUDIER | STRE | TIMORE | | |
| | 31. DASEP (1)117079994 | 32. REGISTRAR'S SIGNAT | URE | | | | | | | |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAND | DEPARTMENT OF | HEALTH AND | MENTAL HYGIEN | | |
|----------------------|--|---|---|-------------------------|--|------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | - | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | WOSENLE | JR. | | SIPT S | 1337 | + |
| | | 5. SEX 6. AGE (In yrs. In | rst birthday) IF UNDER 1 YEAR YRS. MONTHS DAYS | | 7. DATE OF BIRTH (Month, Day, Year) | 0. | BIRTHPLACE (State or Foreign Country) |
| | 9e. FACILITY NAME (If not institution, give s | 21 | | I OR LOCATION OF D | H06.33 | 191311 | IARYLAND |
| Œ | (, | (° | | | EAIH / | 9c. COUNTY | |
| 125 | RESIDENCE OF DECEDENT | | 10 | <u>00200</u> | | DAT | Timore |
| DIRECTOR | 10e. STATE 10b. COUNT | | 10c. CITY, TOWN DR LOC | ATION | | | 10d. INSIDE CITY LIMITS? |
| | 100. STREET AND NUMBER | Llinore | PARK | 341 | | | 1 TYES THE NO |
| FUNERAL | 100. STREET AND NOMBER | VII an P | | Of, ZIP CODE | | 10g, CITIZEN | OF WHAT COUNTRY? |
| N. | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. A | BMED 12 WAS D | SCENDENT OF HIGH | NIC DRIGIN? (Specify Yes | | . S.A. |
| | 1 Never Married 2 Married | FDRCES? 1 YES 2 | NO If yes, | specify Cuben, Maxico | an, Puerto Ricen, atc.) | 10 NO - 14 | . RACE — American Indian, Black, White, atc. |
| BY | 3 Widowed 4 Divorced | | 1 '0" | S 2 MU Specia | Y | | Specify: |
| TED | 15. DECEDENT'S EDU (Specify only highest grade | completed) ((| ECEDENT'S USUAL OCCUPATION of work done during it | TIDN nost of working | 16b. KIND OF BU | SINESS/INDUS | TRY |
| 'LET | Elementery/Secondary (0-12) | College (1-4 or 5+) | le. Do NOT use retired.) | | D - | | C |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | 77 | 7- 5WL - | CONSR | ME (First, Middle, Maiden | عامة | 10. |
| E G | ADOLE | WOERAL | 5 | IS. MOTHER'S NA | THE (FIRST, MIDDIE, MAIDEN | Sumame) | 2/2/2 |
| 5 m | 19a. INFORMANT'S NAME (Type/Print) | | 9b. MAILING ADDRESS (Stree | and Number or Rural | Route Number, City or Tow | n. State. Zip Co | (4) 3/1/3/1 |
| 일 | Rosalis E. L | Nosents 1 | SUR HOZE | KHORO | Rose | Park | wills Ma |
| at be | 20a. METHOD OF DISPOSITION Description 2 Cremation 3 Rem | | AND DATE OF DISPOSITION | Neme of | | CATION - City | or Town, State |
| Huust | 4 Donation 5 Other (Specify) | MOR | rematory or other piece) | MORIAL | 9-3 PA | RKVILL | 5 MARYLAGO |
| examiner | 21. SIGNATURE OF FUNERAL BETTYICE LIN | CENSEE | 22. NAME | AND ADDRESS OF FA | STOF ME | noris | 5 |
| | Wala 42 | Norm A | 880 | | RD Roac | - PAR | kvill |
| medica | 23. PART i. Entar the diseases, or shock, or heart failure | complications that ceuaad the di List only one cause on each lin | aath. Do not enter tha m | node of dying, aud | ch as cardiac or resp | iratory arrest | |
| | IMMEDIATE CAUSE (Final | List only Line Couse on auch in | | | | | intarval Batweer Onset and Deat |
| t, the | disease or condition resulting in dasth) | a ACUTE MYOCAL | RDIAL INFA | RCTION | | | |
| event, | | DUE TO (DR AS A CONSE | | | | | |
| r other traumatic | Sequentially list conditions, if any, leading to immediate | DUE TO (DR AS A CONSE | | MIA | | | |
| CAT LTag | | ACUTE PYELON | JET PHITTS | | | | 1 |
| other TiFi | that initisted aventa | DUE TO (DR AS A CONSE | EOUENCE DF): | | | | |
| 9 111 | resulting in death) LAST | d CHRONIC URET | TERAL OBST | RUCTION | | | |
| 의 그 [| PART II. Other significant condition | na contributing to death but not | reaulting in the underlyl | ng cause given in | Part I. 24a. WAS AN | | 24b. WERE AUTOPSY FINDINGS |
| | HYPERTENSION, | RIGHT HEMIPAR | RESIS (2° | to CVA) | PERFOR | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| shows any : MEDIC | | | | | | NO. | DF DEATH? 1 □ YES 2 XNO |
| 23 sh | | | | | _ | | |
| HYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | PLACE OF DEATH (C) | eck only one) | | |
| YSI | 1 TYES 200 ND | 13% Inpatient 2 - ER/Outpatient : | 3 DOA 4 Nursing Ho | me 5 🗆 Residence | 6 Other (Specify) | | |
| marked, BY PH | 27. MANNER OF DEATH 1 Natural 5 Pending | 28e. DATE DF INJURY (Month, Day, Year) | INJURY Y | JURY AT YORK? | 28d. DESCRIBE HOW I | NJURY OCCUR | ED |
| BY | 2 Accident Investigation | 28e. PLACE DF INJURY — At h | | YES 2 ND | and a contribut to | | |
| | 3 Suicide 6 Could not be 4 Homicide datarmined | building, atc. (Specify) | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| | . CERTIFIER 1 CERTIFYING PHYSI | ICIAN: To the best of my knowledge, d | anth annumed at the time of | | | | |
| | | R: On the basis of examination end/or | | | | | euse(s) end manner as stated. |
| CO | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | 29c. LICENSE NUI | | | IGNED (Month, Day, Year) |
| O BE CO | | on her | | | | DATE SI | 1= 1- : |
| 일 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF DEATH (ITE | EM 27) (\$00 Print) 8035A HZ | D2501(| | | 77794 |
| | DR. ZSRENA | NOLAN, M.D. | | BFORD | D. BALTY | WOKE. | PARKVII. |
| | SEP 0 1994 | 32. REGISTRAR'S SIGNATURE | L . | | | | |
| | JE1 0 . 100 . | ' | | | | | |

| STATE OF MARYLAND | | | | MENTAL | HYGIENE |
|-------------------|-------------------|---------|---|--------|----------|
| C | ERTIFICATE | OF DEAT | Ή | | REG. NO. |

| 73 | | 1 - FOR STATE REGISTRAR | STATE OF MAR | RYLAND | / DEPART | MENT OF | HEALTH AND F DEATH | MENTAL | HYGIENE REG. NO. | | | | |
|--|---------------|--|---|---------------------------|---------------------|-----------------|--|-----------------|---------------------|---------------|-----------------------------------|---|----------|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | AE (First, Middle, Last) 2. DATE OF | | | | | | | YE/ | 4.40 | TIME OF DEATH | |
| | | JOHN 4. SOCIAL SECURITY NUMBER | 1 | AGE (In yrs. I | WITTE | IF UNDER 1 YEAR | | | ep 5 18 | |] | :50 am | M |
| Pi | | 151 07 8145 | 12⊠ M 2 □ F | BS 1 | YRS. | ONTHS DAYS | HOURS MIN. | Nov | Day, Year) | S U 3 | country) | DE (State or Foreign | |
| 2, 3 should | OR | 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF Saint Joseph Hospital Towson, Maryland Ball | | | | | | | OF DEATH | | | | |
| Jes 1, | DIRECTOR | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT | Y | | 10c. CITY, | TOWN OR LOC | CATION | | | | 10d | . INSIDE CITY | = |
| mit. Pag | | MARYLAND BA | WIMORE | | Lī | DWG | 10f. ZIP CODE | | | | | YES 2 NO | |
| 020 physician. burial-transit permit. Pages 1, | FUNERAL | 3710 20152 1 | 2000 | | | | 2123 | 4 | | 10g. CITIZEN | ·S.F | - COUNTRY? | |
| MARYLAND 21215-0020 retained by the hospital or attending physician 5 should be detached for use as the burial-trannotified at once. | BY FU | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EV. FORCES? 136 IF YES, GIVE WAR O | YES 2 | NO 1920 | If yes, | ECENDENT OF HISPA specify Cuben, Mexic ES 2 NO Speci | an, Puarto Ri | | 1 3 | RACE — A Black, Wh Specify: | American Indian, ilte, atc. | |
| 215 attend | 9 | 15. DECEDENT'S EDU (Specify only highest grade | CATION | 16a. C | DECEDENT'S U | SUAL OCCUPA | TION most of working | 16b. | KIND OF BUSIN | IESS/INDUSTI | RY YE | 412 | |
| YLAND 21215-00 by the hospital or attending be detached for use as the at once. | Ē | Elementary/Secondary (0-12) | College (1-4 or 5+) | | fe. Do NOT use | retired.) | most or working | | | | | _ | |
| AND the hosp detacher | COMPLE | 17. FATHER'S NAME (First, Middle, Last) | | 16 | JUARI |) | 18. MOTHER'S NA | | KILLA CIPPLE | | /RC | 121 | _ |
| YL, by the dibe of | BE C | JOHN WITTE | > | | | | (75 DOY | Row | 15.34 (z 6 | | | | |
| MAR retained 5 should notified | TO B | 19e. INFORMANT'S NAME (Type/Print) | | 1 | 19b. MAILING A | DDRESS (Stree | t and Number or Rural | Route Numbe | | | 9) | 31234 | _ |
| | | 200. METHOD OF DISPOSITION | - | 201 71 401 | 3319 | Some | nit Ar | 2 2 | ARNEY | MAG | AFB | 00 | _ |
| BALTIMORE, iter death. Page 6 may be the funeral director, page 7nal. | | 1 Buriel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify) | oval from State | cemetery, c | FAND DATE OF | r place) | | DATE | GAR | RIJO C | or Town, S | 2RYLAND | |
| ALTIN death. Pag t funeral did I. | | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | | 22. NAME | ANO ADDRESS OF FA | ACILITY LLOF | Mzno | Riss | 7 | | |
| BAI after dea by the fur moval. | | Hal of Lie | | | | 880 | OO HARFO | RD R | 000 - | PARKY | 245 | | |
| B ster hours after filled in by the on, or removal the medical | | 23. PART I. Enter the dieeesea, or cehock, or heart fellure. | List only one couse of | used the d on each iir | leeth. Do no ne. | t enter the n | node of dying, aud | ch aa cardi | ec or reapira | tory arrest, | | Approximate intervel Between | |
| hy fille | | IMMEDIATE CAUSE (Fine) disease or condition resulting in death) e. INTRA CEREBRAL HEMORRHAGE | | | | | | | | | | | lh |
| ≥ 2 2 2 2 2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 | 7 | | | | EOUENCE OF): | | | | | | | | |
| | CERTIFICATION | Sequentially liet conditione, if eny, leading to immediate | DUE TO (OR | AS A CONSI | EOUENCE OF): | | | | | | - | | |
| O. BOX ertificate be e ring physician rigiene prior to other traum | FICA | cause. Enter UNDERLYING CAUSE (Disease or injury thet initieted evente | c. DUE TO (OR a | AS A CONSI | EOUENCE OF): | | | | | | | | _ |
| G H B B | ERTI | reaulting in deeth) LAST | d | | | | | | | | | | |
| Me We | 4 | PART II. Other aignificent condition | a contributing to dea | th but not | reaulting In | the underly | ing cause given in | Part i. | 24a. WAS AN AL | | | E AUTOPSY FINDING | s |
| RECORL requires that the signed by of Health and shows any in | MEDIC | CONGESTIVE HEAF | T FAILURE | | | | | | PERFORM | | COM | LABLE PRIOR TO IPLETION OF CAUSE DEATH? | |
| | : ME | CHRONIC RENAL DI DID TOBACCO USE CONTI | | C OF DE | ATLL VEC | | - UNICEDIAL | | | . | 1 🗆 | YES 2 NO | |
| AL he law bept Dept | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | ATT TES | | | NU | | | | | \dashv |
| OF VITA IYSICIAN: The State if the State ide. | YSIC | 1 TYES TO NO | HOSPITAL: | Outpatient | | THER: | ome 5 - Rasidence | 6 Other | (Specify) | | | | |
| Mit the | | 27. MANNER OF DEATH 7. Netural 5 Pending | (Month, Day, Ye | | 26b. TIME (| IY V | NJURY AT YORK? YES 2 NO | 28d. DESC | RIBE HOW INJ | URY OCCURE | D | | |
| 3 4 | р Вү | Accident Investigation 3 Suicide 8 Could not be | 28s. PLACE OF INJ | IURY — At h | nome, farm, atro | | | 28f. LOCA | TION (Street and | Number or Ru | iral Route | Number, | \dashv |
| | ETED | 4 Homicide determined | bonding, arc. (| эреспу) | | | | City of | Town, State) | | | | |
| SPITAL D | COMPLE | | CIAN: To the best of my k | | | | | | | | ise(a) and | menner es stated. | |
| TO THE HOSPIT TO THE FUNER Be find within IMPORTANT. | BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER | 0 - ' | 0 1 | | | 29c. LICENSE NU | MBER | 2 | 29d. DATE SIG | NEO (Mon | th, Day, Year) | + |
| ₽ ₽ ₽ ₽ ₹ | 6 | 10. HAME AND OFFICES OF PERSON WH | O COMPLETED CAUSE OF | hte. | M 137 (300 B | nine) | D41410 | | | 6-6 | -05 | -94 | 4 |
| | | JOGINDER P. MEHT | TA M.D., ST. | JOSE | PH HO | | 7620 YOR | K RD., | TOWSO | N, MD | 2120 |)4 | |
| | | 31. D'SELP (Portif 01994 | 32. REGISTRAR'S S | SIGNATURE | u, | | | | | | | | |

.

8. BIRTHPLACE (State or Foreign

Maryland

14. RACE — American Indian, Black, Whita, atc. Specify White

> Approximate interval Between Onset and Death

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 TYES 2 NO

end due to the cause(s) end manner as stated.

10d. INSIDE CITY LIMITS? 1 VES 2 NO

9c. COUNTY OF DEATH

3. TIME OF DEATH

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1 - FOR STATE REGISTRAR

2. 3 should

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

217 12 6856

SEP 0 1 1994

MELVIN

5. SEX

90. FACILITY NAME (If not institution, give street and number)

Bay View Medical Center

1€ M 2 □ F

| 2.3 | OR B | Bay View Medical Center | | | Baltimore | | - | |
|---|-----------------|---|---|------------------|--|--|-----------------------------|---|
| BALTIMORE, MARYLAND 21215-0020 er death. Page 6 may be retained by the hospital or attending physician. the tuneral director, page 5 should be detached for use as the burial-transit permit. Pages 1. Ind. It is examiner must be notified at once. | DIRECTOR | 10a. STATE 10b. COUNTY Maryland Baltimore | 10c. CITY | r, TOWN OR LO | imore | | | 10d. INSIDE CITY LIMITS? 1 YES 2 |
| | ERAL | 100. STREET AND NUMBER 438 Oriole Ave. | | | 101, ZIP CODE 21224 | | | OF WHAT COUNTRY? |
| | BY FUNI | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER FORCES? 1 YES, OVER WAR OF | S 2 2NO | If yes, | ECENDENT OF HISPANIC O specify Cuben, Maxican, Pu ES 2 NO Specify: | RIGIN? (Specify Yes erto Rican, etc.) | 1 | RACE — American India Black, Whita, atc. Specify: White |
| | APLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | life. Do NOT us | vork done during | most of working | 16b. KIND OF BUS | onstruc | |
| | E COMP | 17. FATHER'S NAME (First, Middle, Last) Albert Wiegand | | | 18. MOTHER'S NAME (I | First, Middle, Melden Primus | Surname) | |
| | TO B | 190. INFORMANT'S NAME (Type/Print) Pearl Johnston | 196. MAILING 516 | Dorsey | Ave. Pal | Number, City or Town | MD 2122 | 'n |
| ALTIMORE, seath. Page 6 may be furneral director, page xaminer must be | | 4 Donation 5 Other (Socoty) | ORK LAWD | Come te | ry 9/7 | 94 20c LO | cation — city of Ltimore | GO a MD |
| BALTIMORE, after death. Page 6 may be y the funeral director, page noval. | | 21. SIGNATURE OF PUNEARLY SERVICE LICENSEE | he | | dzinski Fund Eastern Ave | | | MD 21221 |
| P.O. BOX 68760 th certificate be executed with chours alt cerding physician and completely filled in by all Hygiene prior to burial, cremation, or remo or other traumatic event, the medical | L CERTIFICATION | Sequentieity list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury. | S HOC S A CONSEQUENCE OF S A CONSEQUENCE OF | K PNE 7: | UMONIA | i. 24s. WAS AN | AUTOPSY | Approximinterval Be Onset and |
| L RECORDS, law requires that the dea as been signed by the att lept. of Health and Menta 23 shows any finjury, | N: MEDICAL | RENAL FAILURE | | | | PERFOR | MED? | AVAILABLE PRIOR COMPLETION OF COF DEATH? |
| TA The age that the age to the the the the the the the the the the | YSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 YEO 1 Inpellant 2 ER/O | utpatient 3 DOA | OTHER: | PLACE OF DEATH (Check of | | | |
| | BY PHYS | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 28. DATE OF INJUR (Month, Day, Yea | Y 28b. TIMI INJ | M 1 | WORK? YES 2 NO | DESCRIBE HOW II | | |
| HETH After After Acte Acter Acter Acter Acter Acter Acter Acter Acter Acter Acter Acte Acter Acte Acter Acter Acter Acter Acter Acter Acter Acter Acter Acter Acte Acter Acte Acter | ETED | 4 Homicide determined building, atc. (S | pecify) | | | LOCATION (Street a City or Town, Stete) | | irai Houte Number, |
| | COMP | (Check only 1 CERTIFYING PHYSICIAN: To the best of my kn one) 2 MEDICAL EXAMINER: On the basis of axamina | | | | | | rse(s) end manner as s |
| TO THE H TO THE F Se filed w | TO BE | 296. SIGNLY URBAND TITLE OF CERTIFIER | MD | | 29c. LICENSE NUMBER | | ≥ O | POYG |
| | - | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED AUSE OF | DEATH (ITEM 27) (Type, | Print) Paste | THE ALE | Ralto | MO | 21224 |

32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR

DAYE

IF UNDER 24 HRS.

9b. CITY, TOWN OR LOCATION OF DEATH

6. AGE (In yrs. last birthday)

YRS.

73

2. DATE OF DEATH

7. DATE OF BIRTH (Month, Day, Year)
Dec. 17,

DHMH-16 Rev 1/89

colven A segund

217 12 5856 M 73 Dec. 17, 1920 Paryland

Day yes Medical Center | mitimore

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rest voiceton 510 corsey ave. Falthore, (1 022)

IC . 60 Promities #9/9/9 vanished nucl 160 . X

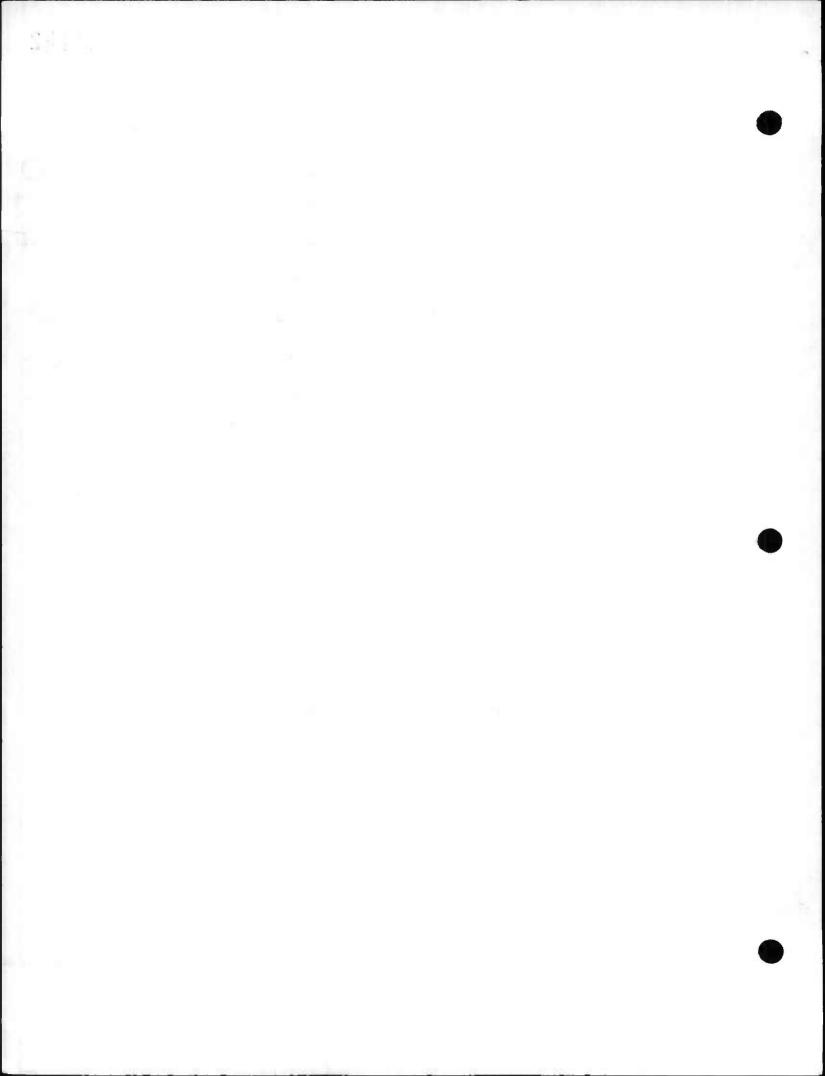
irusdainski Puteral Home sk 1407 issteim Ave. Esitim re, No 2120

by the hospital or attending physician. It is be detached for use as the burial-transit permit. Pages 1, 2. 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained to | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should | | IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified |
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| may | or. pe | | ust t |
| age 6 | direct | | E TE |
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| HYS | his c | with | ked. |
| NG P | fter t | eath | mar |
| END | JR: A | ter d | 80 |
| A ATT | RECT | IFS at | 2 E |
| AL 06 | IC DI | 2 2 | f ite |
| SPIT | NERA | thin 7 | N. |
| 모 | E FU | hw be | MITA |
| 101 | 101 | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | MPC |
| | | _ | |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | MENT OF H | | MENTAL HYGIENE REG. NO. | | | | | | |
|------------------|--|---|-------------------------------------|-----------------------|--------------------------------|--|------------------|-------------------------------------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | | |
| | ERNEST WALKER | | | | | SEPTEMBER | 2 1992 | 6:50 P M | | | | |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | S. BIR | THPLACE (State or Foreign | | | | |
| | 218-60-2606 | 1 🕅 M 2 🗆 F | 41 YRS. | WONTHS DATS | HOURS MIN. | May 20, 19 | | ryland | | | | |
| 6 | 9s. FACILITY NAME (If not institution, give | | | | R LOCATION OF DE | | 9c. COUNTY OF | DEATH | | | | |
| DIRECTOR | THE JOHNS HOPKI | NS HOSPITAL | | BALTIM | ORE CITY | (| N/A | | | | | |
| E C | 10s. STATE 10b. COUNT | TY | 10c. CITY | TOWN OR LOCAT | ION | | | 10d. INSIDE CITY | | | | |
| 븝 | MD N/A Baltimore 1X yes 2 N | | | | | | | | | | | |
| AL | 10e, STREET AND NUMBER | | | | | | | | | | | |
| FUNERAL | 317 E. North Avenue Apt. 210 21202 U.S.A. | | | | | | | | | | | |
| <u> </u> | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | | | | C ORIGIN? (Specify Yes o | | CE — American Indian, | | | | |
| BY F | 1 X Never Merried 2 Merried 3 Widowed 4 Divorced | FORCES? 1 YES | ATES | 1 TYES | 2 NO Specify: | | | netty: | | | | |
| ED E | 15. DECEDENT'S EDU | ICATION | 44. DEGEDANTIA | | Λ | <u> </u> | | Black | | | | |
| ITE | (Specify only highest grad | e completed) | (Give kind of w life. Do NOT use | ork done during mo: | | 16b. KIND OF BUSIN | IESS/INDUSTRY | | | | | |
| PLE | Elementary/Secondary (0-12) | College (1-4 or 5 +) N/A | N | | | N/A | | | | | | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | N/A | 11/ | A | 16. MOTHER'S NAM | NE (First, Middle, Maiden Su | | | | | | |
| EC | Thomas Jackson | | | | | oeth Holmes | , | | | | | |
| (CO | 19s. INFORMANT'S NAME (Type/Print) | - | 19b. MAILING | ADDRESS (Street a | nd Number or Rural R | oute Number, City or Town, | State, Zip Code) | | | | | |
| 10 | Rose Hurt | | 910 H | omestead | Street/ | Baltimore, | MD 212 | 18 | | | | |
| | 20s. METHOD OF DISPOSITION | noval from State | PLACEAND DATEO | | ma of | DATE 20c. LOCA | TION — City or | Town, State | | | | |
| | 1 🔀 Buriel 2 🗆 Cremation 3 🗆 Ren 4 🗓 Donation 5 🗆 Other (Specify) | | SHELL ME | | GARDENS | Dunda | alk, MD |) | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | ICENSEE | | | D ADDRESS OF FAC | | | | | | | |
| | - uness- | MA | | 1101 E | . North | Home East Ave./Baltim | ore, M | D 21202 | | | | |
| | 23. PART i. Enter the diseases, pr | complications that cause. List pniy one cause on a | the death. Do no | ot antar tha mo | da of dying, such | as cardiac or reapira | tory arrest, | Approximata | | | | |
| | IMMEDIATE CAUSE (Final | List brily one cause on a | acii iiria. | | | | | intarval Between Onset and Death | | | | |
| | disease or condition resulting in death) | . Hodakin | 5 Diseas | se . | | | | month | | | | |
| | | DUE TO OR AS | CONSEQUENCE OF | : |) | | | D | | | | |
| NO | Sequantially list conditions, | a Hutoimmy | ne Vetic | ilry Jy | ndrone | | | 0 years | | | | |
| AT | if any, leading to immediate cause. Enter UNDERLYING | DOE TO (OR AS) | CONSEQUENCE OF | . / * | | | | | | | | |
| FIC | CAUSE (Disease or injury that initiated events | C. DUE TO (OR AS A | CONSEQUENCE OF |): | | | | | | | | |
| CERTIFICATION | resulting in death) LAST | d. | | | | | | | | | | |
| | PART II. Other eignificant condition | ne contributing to death h | ut not resulting in | the underlying | | | | | | | | |
| CAL | TART III. GUILLE AGUITAGUI | tia contributing to death t | ut not reauting in | ı ına underiying | cauaa given in i | PERFORM | ED? | AMAILABLE PRIOR TO | | | | |
| <u> </u> | | | | | | 1 □ YES 2/E | NO | OF DEATH? | | | | |
| PHYSICIAN: MEDIC | DID TOBACCO USE | CONTRIBUTE TO | CALISE OF | DEATH Y | YES NO | | | 1 TYES 2 THO | | | | |
| NA N | 25. WAS CASE REFERRED TO MEDICAL | T T | CAUGE OF | | ACE OF DEATH (Che | / | | | | | | |
| SIC | EXAMINER? | HOSPITAL: | | OTHER: | e 5 🗆 Residence (| | | | | | | |
| H | 27. MANNER OF DEATH | 28s. DATE OF INJURY | 26b. TIME | OF 28c, INJ | URY AT | 28d. DESCRIBE HOW INJ | URY OCCURED | | | | | |
| ВУР | 1 Netural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJU | | RK? 'ES 2 NO | | | | | | | |
| | 3 Suicide 6 Could not be | 26e. PLACE OF INJURY building, etc. (Spe- | - At home, ferm, st | reet, lactory, office | | 281. LOCATION (Street end | Number or Rura | I Route Number, | | | | |
| | 4 Homicide determined | | " | | | City or Town, State) | | | | | | |
| P | | SICIAN: To the best of my know | ledge, death occurre | d at the time, data | and place, end due t | to the cause(s) and manne | er as stated. | | | | | |
| COMPLETED | | ER: On the besis of examination | | | | | | o(s) end menner es stated. | | | | |
| BE C | 29b. SIGNATURE AND TITLE OF CERTIFIE | 1. O | | | 29c. LICENSE NUM | BER 2 | ed. DATE SIGNE | ED (Month, Day, Year) | | | | |
| 10 B | Perhad Vi | 1 191 | | | M619 | 9 | ► 9/2 | 184 | | | | |
| - | 30. NAME AND ADDRESS OF PERSON WI | HO COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type, | Print) | 1. | 11 61 | | | | | | |
| | 31. DATE FILED (Month, Day, Year) | lower 110 | J J | ohns /ti | office / | taspire! | | | | | | |
| | SFP 0 7 1001 | 32. REGISTRAR'S SIGN | ATURE 11 | | | / | | | | | | |
| | ULI U 1 1334 /100 | Again, water of | ~ | | | | | | | | | |



ITEMS: 10e, 10f, PER F.H. FILM G-715 9/15/94 t.t Item 17, g-715, 9-7-94, per F.H., dr

FOR 1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | | REGISTRAR | | CERTIFICA | ATE O | F DEATH | REG. NO |). | | | | | | | |
|--|---------|--|---|---|----------------------|---|--|----------------------------------|--|--|--|--|--|--|--|
| | | DECEDENT'S NAME (First, Middle, Last) AL | BERT J. W | OMACK | | | 2. DATE OF DEATH MONTH D | 1994 | 3. TIME OF DEATH | | | | | | |
| 2 | | 4. SOCIAL SECURITY NUMBER 5. SEX 1X 1 | 6. AGE (In yrs. | | THE DAYS | | 7. DATE OF BIRTH (Month, Day, Year) 8-7-1928 | 8. BIRT Count | HPLACE (State or Foreign (ry) V a | | | | | | |
| 2, 3 should | СТОВ | 9e. FACILITY NAME (If not institution, give street and 2932 Oakford Aven | | 9b. | Balt | OR LOCATION OF OR | ATH | 9c. COUNTY OF I | DEATH | | | | | | |
| - SS | 딥 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10c. CITY, TO | WN OR LOC | ATION | | | 10d, INSIDE CITY | | | | | | |
| permit. Pages | DIR | Md | ······································ | Balte | 0 | | | | 1 X YES 2 NO | | | | | | |
| ian. transit per | NERAL | 2932 Oakford Avenue | Apt 1 | | | 10f. ZIP CODE 21215 | 21216 | US | | | | | | | |
| 20050 X | BY FUN | 1 Never Married 2 Merried FOF ST Wildowed 4 Divorced | S OECEDENT EVER IN U.S. RCES? 1 [X] YES 2 [YES, GIVE WAR OR DATES | ARMED NO | It yes, | ECENDENT OF HISPAN specify Cuban, Mexicon ES 2 NO Specify | | e or No— 14. RAC Blac Spec | E — American Indian, ck, White, etc. | | | | | | |
| Z121 | LETE | 15. DECEDENT'S EDUCATION (Specify only highest grade complete Elementery/Secondary (0-12) Colleg | d) 16a. e (1-4 or 5+) | DECEDENT'S USUA (Give kind of work of life. Do NOT use reti | done during i | TION most of working | | SINESS/INDUSTRY | | | | | | | |
| O de de | MPL | 7th | | | | | High's | S | | | | | | | |
| ty the dots of all all and | 1 144 1 | 17. FATHER'S NAME (First, Middle, Last) Char. | DWack 18. MOTHER'S NAME (First, Middle, Meiden Surneme) Bessie Elliott | | | | | | | | | | | | |
| MAR retained 5 should notified | TO B | 19e. INFORMANT'S NAME (Type/Print) | | | | | loute Number, City or Tow | rn, State, Zip Code) | | | | | | | |
| 8 6 | | Theresa Owens | | 2932 0 | akfor | d Avenue | Balto, Md | | | | | | | | |
| C E V W | | 20e, METHOD OF DISPOSITION 1 A Burlet 2 Cremetion 3 Removal from 4 Donation 5 Other (Specify) | n State comptony | crematory or other p | tecni | | | vings Mil | | | | | | | |
| BALTIMOR BALTIMOR after death. Page 6 min y the funeral director moval. ical examiner municipal | | 21. SIGNATURE OF FUNERAL SERVICE LICENSHE | 22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue Balto, Md 21215 23. PART I Inter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiretory arrest, Approximate | | | | | | | | | | | | |
| tely filled in by remonation, or remo | | 23. PART I that the diseases, or complications, or heart failure. List only IMMEDIATE CAUSE (Final disease or condition resulting in death) | y ona cause on each ii | idiop | ntar tha n | noda of dying, suct | rdiomy | iretory arreat, | Approximata Interval Between Opent and Death | | | | | | |
| certificate be executed ing physician and cylogiene prior to buriar other traumatic | RTIFIC | Sequentistly list conditions, if any, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST | DUE TO (OR AS A CONS | | | | | | | | | | | | |
| at the death by the atter and Mental y injury, o | 1 11 | PART II. Other significant conditions contri | buting to death but no | ot resulting in th | e undariyi | ng causa given in | Part I. 24s. WAS AN | AUTOPSY 240 | o. WERE AUTOPSY FINDINGS | | | | | | |
| any any | 2 | Atrial F | lutter | | | 22 % W | PERFOR | RMED? | AVAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? | | | | | | |
| S b b | AN: MI | DID TOBACCO USE CONTRIBUTE | TO CAUSE OF DE | EATH YES [|] NO | UNCERTAIN | X | | 1 TES 2 NO | | | | | | |
| e ate h | SICI | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 28. PL PITAL: | ACE OF OEATH (C) | heck only on HER: | e) | | | | | | | | | |
| SICIAN: The certificate of the State of the State | PHYS | | e. DATE OF INJURY | | _ | me 5 Residence | | | | | | | | | |
| 子 語 · 多 | BY PI | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | 28b. TIME OF INJURY | M 1 [| NJURY AT YORK? YES 2 NO | 28d. DEŞCRIBE HOW I | NJURY OCCURED | | | | | | | |
| TTEN TOR: after | TED | 3 Suicide 8 Could not be 4 Homicide determined | PLACE OF INJURY — At building, etc. (Specify) | home, farm, street. | , fectory, of | lice | 281. LOCATION (Street and City or Town, State) | | Route Number, | | | | | | |
| R Por July | PLE | 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To | the best of my knowledge, | death occurred at | the time, da | te end place, and due | to the cause(e) end me | nner as atated. | | | | | | | |
| HOSPITAL FUNERAL within 72 | COMPL | one) 2 MEDICAL EXAMINER: On the | beele of exemination end/ | or Investigation, in | my opinion, | death occured at the | time, data and place, en | id due to the cause(| e) end menner ee stated. | | | | | | |
| TO THE HOSPITAL TO THE FUNERAL De filed within 72 #MPORTANT: It | BE | 296, SIGNATURE AND TITME OF CERTIFIER | M.D. | | | 29c. LICENSE NUM | BER 7.7 | 29d. DATE SIGNED | (Month, Day, Year) | | | | | | |
| FFă | 5 | AME AND ADDRESS OF PERSON WHO COMPL | ETED CAUSE OF DEATH (IT | | pit | al 1 | 3altin | 10/6 | MN | | | | | | |
| | | | REGISTRAR'S SIGNATURE | - Handelle | | / | | | - 1.7 | | | | | | |
| | !!! | | TWF | | | | | | | | | | | | |

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DHMH-16 Rev 1/89

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| BALTIMORE, MARYLAND 21215-0020 | ALTAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician. | centificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | medical examiner must be notified at once. |
|---|---|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | TO THE HOSPITAL OR TERMING PRESIDAN. The law requires that the death certificate be executed with | TO THE PLINEAR DIFFERENCE AND COMPLETE AND ASSOCIATED BY THE ATTENDING PHYSICIAN AND COMPLETED FILLED BY THE 1 OF THE WITHIN TO DOURS THE DEST WITH A STATE DEPT. OF HEATH AND MENTAL HYGIENE prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

FOR STATE REGISTRAR

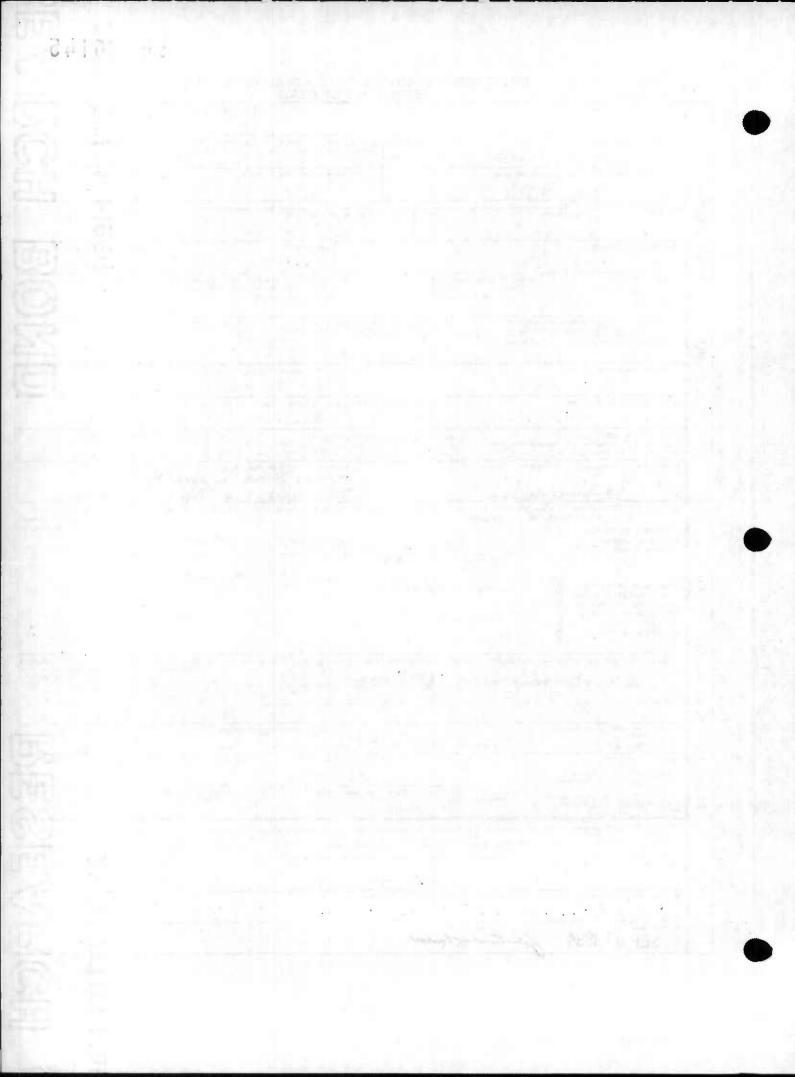
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH | | | | | | | | | | | 3. TIME OF DEATH | | | |
|--|--|--------------------------|-----------------------------------|---|---------------------------------------|------------------------|----------------------|-------------------|-----------------------|-------------------------------|-----------------------------------|----------------------------|-------------|--|
| Í | Gordon | WELLS | | | | | MONTH DAY YEAR | | | | 12:45 P M | | | |
| ; | 4. SOCIAL SECURITY NUMBER 257 09 2 | | 5. SEX 6. AGE (In yrs. last birth | | | MONTHS DAYS HOURS MIN. | | | 24 HRS. | 7. DATE OF BIRTH 8. BIRT | | | | LACE (State or Foreign |
| | 9e. FACILITY NAME (If not in | stitution, give s | treet and number) | | | 9b. CITY | , TOWN (| OR LOCATE | ON OF DE | | | 9c. COU | INTY OF DE | |
| S S | Franklin | Squar | e Hospit | al | | Rossville Baltimor | | | | | | timor | e County | |
| 5 | RESIDENCE OF DEC | EDENT | | | | | | | | | | | | |
| DIRECTOR | Md. 100. STATE Baltimore | | | | | ssex | | NON | | | | | | 10d. INSIDE CITY LIMITS? 1 XES 2 NO |
| FUNERAL | 100. STREET AND NUMBER | | ! | | 101. ZIP CODE 21221 | | | | | | 10g. CITIZEN OF WHA | | | HAT COUNTRY? |
| 2 | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— 14. RACE — / 1 Never Merried 2 Theorem (Specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — / 15. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— 14. RACE — / 15. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 15. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 15. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 16. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 16. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 16. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 16. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 16. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 16. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 16. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 16. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 16. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 16. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 16. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 16. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 16. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 16. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 16. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 16. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 16. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 16. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 16. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 16. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 16. Was Decendent of Nispanic Origin? (Specify Yes or No— 14. RACE — / 16. Was Decendent of Nispanic Origin? (Specify Yes or No— 1 | | | | | | | | | | - Americen Indian, White, etc. | | | |
| BY F | 1 Never Merried 2 🔀 3 Wildowed 4 Divo | | IF YES, GIVE Y | WAR OR DATES | | | | 2 NO | | | n, etc.) | | Specify | |
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| E | (Specify ont | EDENT'S EDU | completed) | (GI | CEDENT'S ve kind of v Do NOT us | vork done | | | g | 16b. KIN | D OF BUS | SINESS/IN | DUSTRY | |
| COMPLETED | Elementary/Secondary (0 | | College (1-4 or 5 | +) | | hini | .st | | | | | el Co | ٥. | |
| BE CO | 17. FATNER'S NAME (First, M John Tho | | lla | | | | | | | ME (First, Middle L'rice \ | | | | |
| 10 | Ellen P. | | | 198 | 12 | Orte | s (Street s ega I | ane | or Rural F | Poute Number, 0 | Ny or Town | n. Slate, <i>Zi</i> 221 | p Code) | |
| | 20e. METNOD OF DISPOSITI | ON 3 - Rem | oval from State | 20b. PLACE A cemetery, crea Green | IND DATE O | of Dispos | rem? | atory | 9- | 7-94 | | cation – | City or Tow | rn, State |
| | Campetery, cremetory or other place Campetery or other place Campetery or other place Campetery or other place Campetery or other place Campetery Charles Campetery | | | | | | | | | | | | | |
| į, | - Charl | | D. Zil | | | | 6224 | 1 Eas | terr | a Aveni | ae Ba | alto. | .,Md. | |
| | 23. PART I. Entar tha diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between | | | | | | | | | | | | | |
| | IMMEDIATE CAUSE (Final | | | | | | | | | | | | | |
| | resulting in death) | → | Stroke | | | | | | | | | | | 7 days |
| | | | DUE TO | (OR AS A CONSEC | UENCE OF | F): | | | | | | | | |
| O | Sequentially list conditi | | b. DUE TO | (OR AS A CONSEC | LIENCE OF | n. | | | | | - | | | |
| EA! | If sny, leading to imme- cause. Enter UNDERLY! | | | (on no n conce | OLIVOL OF | ,. | | | | | | | | i l |
| 밀 | CAUSE (Disease or Inju that initiated evanta | iry | DUE TO | (OR AS A CONSEC | UENCE OF | F): | | | | | | | | - |
| CERTIFICATION | resulting in death) LAS | т. | d. | | | | | | | | | | | |
| | DART II Other elevition | nt condition | a a a a delbudia a de | double have a second | | | | | | | | | | |
| MEDICAL | PART II. Other significa | CONGILION | s contributing to | daath out not h | esulting i | n the ur | iderlyin | g cause g | given in | Part I. 244 | PERFOR | | | WERE AUTOPSY FINDINGS AMILABLE PRIOR TO |
| ă | | | | n | | | | | _ | _ 1 | YES 2 | NO X | | COMPLETION OF CAUSE OF DEATH? |
| - 1 | | | | | | | | | | | | | | 1 YES 2 NO |
| S S | 25. WAS CASE REFERRED TO | | | | | | | | | | | | | |
| PHYSICIAN: | EXAMINER? | O MEDICAL | HOSPITAL: | | | OTHE | | ACE OF D | EATN (Che | eck only one) | | | | |
| ₹ | 1 YES 2 NO | | 1X Inpatient 2 | ER/Outpatient 3 | | | sing Hom | | sidence | 6 Other (Sp | | | | |
| BY PH | 1 📉 Natural 5 🗌 | Pending Investigation | (Month, E | Pay, Year) | | URY M | 1 🗌 ' | PRK? | NO | 28d. DEŞCRI | BE HOW IF | NJURY OC | CURED | |
| 28e. PLACE OF INJURY — At home, farm, street, tectory, office 4 Homicide 28e. Could not be determined 2 | | | | | | | | | oute Number, | | | | | |
| | | | | | | | | | end menner as stated. | | | | | |
| 20h SICNATIIDE AND TITLE OF DEDTIFIED | | | | | | | | | | | | | | |
| TO BE | Mon. 30. NAME AND ADDRESS OF | XYC | . po | 05.04.05 | 45 | | | | | | | ▶ 7 | 15/5 | 4 |
| | Martin, Li | | | | | | in c | <i>(</i> 1110 ×) | . D | irro D | 743 | | | 1007 |
| | 31. DATE FILED (MONIN DEC) | YMar) G | | RIS FIGURES | O III | TAILT. | TII D | quar | e Dr | ive Ba | TC1m | ore . | Md. 2 | 1237 |
| | 31. SEE PLED (MOVING 99 Yer) July 3207ECHSTEAD O RIGHARDA | | | | | | | | | | | | | |

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| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with |
| 5 | OR |
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| | 1 - FOR STATE REGISTRAR | | | / DEPAR | | | | | MENTAL HYGIE REG. N | | | |
|--------------------|--|---|------------------------|---------------------------------|------------------------------|-----------------|---------------|------------|--|-------------------------|---------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF DEATH MONTH | DAY | YEAR 3. 1 | TIME OF OEATN |
| | MARIE E | | | | LHELM | | | | 09 04 | 25 PM M | | |
| | 4. SOCIAL SECURITY NUMBER | MONTHS DAVE MONTHS AMM (Morth, Day, Year) | | | | | | | | 8. BIRTNPLA Country) | CE (State or Foreign | |
| | 214-22-1572 | 1 M 2 X F | 87 | | | | | 5-6-190 | | Many. | | |
| 00 | 9a. FACILITY NAME (If not institution, give | | | | 9b. CITY, 1 | | | | EATH | 9c. COU | NTY OF OEATH | and Same |
| 5 | NORTH ARUNDEL HO | SPITAL AS | SOCIATI | LON | GLE | EN B | URN] | (E | | A | A. CC | UNTY |
| DIRECTOR | 10a. STATE 10b. COUNT | | | 10c. CIT | Y, TOWN OR | | | | 11117 | | 10d | I. INSIDE CITY LIMITS? |
| | Md. Ann | re Aruno | lel | | Gle | en l | Buri | nie | | | 1 [| YES 2 X NO |
| \¥ | 10a, STREET AND NUMBER | | _ | | | 10f. | ZIP COD | | | 10g. CITt | ZEN OF WHAT | |
| FUNERAL | 36 A Cedar Di | | | | | | 2/0 | 060 | | | 4.5. | .A. |
| Ξ | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS OECEOEI FORCES? | NT EVER IN U.S. | | | | | | NIC ORIGIN? (Specify Y | ea or No— | 14. RACE — A Black, Wi | American Indien, nite, etc. |
| B⊀ | 3 XWidowed 4 Divorced | IF YES, GIVE | MAR OR DATES | | 1 (| YES | 2 📉 NO | Specif | y: | | Specify: | White |
| | 15. OECEOENT'S EO | UCATION | 16a, | OECEOENT'S | USUAL OCC | CUPATIO | IN . | | 16b, KINO OF B | USINESS/IND | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| ET | (Specify only highest gred Elementary/Secondary (0-12) | le completed) College (1-4 or 5 | | (Give kind of life. Do NOT u | work done du se retired.) | ring mos | st of worki | ing | | | | |
| 릴 | | | | Homen | naken | Z | | | H | Ome | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOT | | ME (First, Middle, Maide | | | 1 |
| BE | William H. St | raney, Si | | | | | | Mai | rgaret Z | ick | | 100 |
| TO BE CON | 19a, INFORMANT'S NAME (Type/Print) | 1 1. | | 19b. MAILING | AOORESS | (Street a | nd Numbe | r or Rural | Route Number, City or R | wn, State, Zip | Code) | (0 |
| | Mrs. Helen M. | Larren | | 30 A | Leda | in i | Ur. | 916 | en Burni | | | |
| | 20a, METHOD OF DISPOSITION 1 XBurial 2 Cremation 3 Res | moval from State | 20b. PLAC | E ANO OATE | of OISPOSIT | TION (Na | me of | | DATE 20c. 1 | _ | City or Town, | |
| | 4 Donation 6 Other (Specify) Ledan Hill Lemetery 9/8 Balto., Md. | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ACCORES OF FACILITY HARTLEY Miles FUNCEAL HOME | | | | | | | | | | | |
| | Marland | Helle | | | 7 | 152 | 7 4 | ARFO | RD Rd. BA | N. OT | N. 21 | 334 |
| | 23. PART I. Enter the diseases, or shock, or heert fellure IMMEDIATE CAUSE (Final disease or condition resulting in death) | . List only one ca | use on each II | ne. | | | | | | piratory an | reat, | Approximate Interval Between Onset and Daath |
| CERTIFICATION | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST CATAGO TESPITY: Terminal CATAGO TESPITY: Termina | | | | | | | | | | | |
| | PART II. Other significent condition | ons contributing to | deeth but no | t resulting | In the und | lerivino | ceuse | given in | Part I. 24s. WAS | N AUTOPSY | 24b. WE | RE AUTOPSY FINDINGS |
| PHYSICIAN: MEDICAL | vendra | | | | | | | | PERF. | DRMED? | COL | ALABLE PRIOR TO MPLETION OF CAUSE OEATN? YES 2 NO |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER: | | ACE OF | DEATH (C/ | neck only one) | | | |
| YSICI | 1 YES 2 NO | 1 - Inpatient 2 | | 3 🗆 DOA | | | 6 🗆 A | lesidence | 6 Other (Specify) | | 20 | |
| PH | 27. MANNER OF CEATH | 26a. OATE O (Month, | F tNJURY Day, Year) | 26b. TIN | JURY 2 | 28c. INJI WO | URY AT RK? | | 28d, OEŞCRIBE HOV | INJURY OC | CUREO | |
| ВУ Р | 1 Natural 5 Pending 2 Accident Investigation M 1 YES 2 NO | | | | | | | | | To be | | |
| ETED | 3 Suicide 5 Could not be determined 28e. PLACE OF INJURY — At home, term, street, factory, office 281, LOCATION (Street and Number or Bural Route Number, City or Town, State) | | | | | | | | | Number, | | |
| BE COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PNY | | | | | | | | to the cause(s) and no time, date and place, | | | d manner as stated. |
| 0 | 29b. SIGNATURE AND TITLE OF CENTURE | ER | | | | | 29c. LIC | ENSE NU | MBER | 29d. DAT | E SIGNER (Mo | nth, Day, Year) |
| 5 J III | 18 | | - 2 | 105 | | | 0 | 23 | 624 | > < | 71519 | rc . |
| O BE | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BASANT K KHANDELWAL, M.D./1600 CRAIN HIGHWAY, SW, #201/GLEN BURNIE, MARYLAND 2106 | | | | | | | | | | | |
| TO BE | 30. NAME AND ADDRESS OF PERSON W BASANT K KHANDELI | WAL, M.D. | /1600 (| TEM 27) (Type CRAIN | , Print) HIGHW | ΙΑΥ, | SW, | , #20 | 01/GLEN BU | RNIE, | MARYL | AND 2106 |



DIVISION OF VITAL RECORDS, P.O. BOX 68760.

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| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. |
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| - 1 | 1. DECEDENT'S HAME (First, | | Burton | Whipp | 0 | | | 2. DATE MONTH Sep | t. 6, | 1994 | YEAR | 3. TIME OF DEA |
|-------------------------------|--|--|--|--|--|--------------------------------------|--|---|---|--|--------------------------|---|
| | 4. SOCIAL SECURITY NUMB 122-10-254: | | 5. SEX 1 M 2 F | | yrs. lest birthday) 77 YRS. | IF UNDER 1 YEA | | 7. DATE (| OF BIRTH | T. | BIRTHI Country Pen | PLACE (State or Fi |
| стов | Se. FACILITY HAME (If not ins Cherrywe | | anor Exte | nded | Care | | WN OR LOCATION OF C | | | 9c. COUNT | Y OF DE | |
| DIRECT | RESIDENCE OF DEC | TOWN OR LO | CATION Mills | | | 10d. IHSIDE CITY LIMITS? 1 YES 2 MO | | | | | | |
| ETED BY FUNERAL | 100. STREET AND NUMBER | radbui | ry Rd. | | | | 101. ZIP CODE 21117 | | | | _ | HAT COUHTRY? |
| | 11. MARITAL STATUS 1 Never Married 2 🔏 3 Widowed 4 Divos | | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | YES | 2 NO | If yes | DECENDENT OF HISPA is, specify Cuban, Maxic YES 2 A NO Speci | an, Puerto R | ? (Specify Yes lican, etc.) | or No — 1 | Black, Specify | - American Indi White, etc. |
| | | EDENT'S EDU y highest grade | | | 6a. DECEDENT'S U (Give kind of wo Me. Do NOT use Sales | ork done during retired.) | PATIOH g most of working | 16b. | KIND OF BUS | iness/indu | | |
| E COMPI | 17. FATHER'S HAME (First, Mil Clyde | | n Whippo | | | | 18. MOTHER'S N | me Ge | liddle, Maiden S tz | Sumame) | | |
| TO BE | 19a. INFORMANT'S HAME (7) Dorothy | | 0 | | 19b. MAILING A | ADDRESS (Sm | Rd., Owi | ngs M | er City or Town | Md. Z | 2111 | 7 |
| | 20s. METNOD OF DISPOSITI | n 3 🗆 Rem | noval from State | comete | ACEAND DATE OF OTHER PROPERTY. Crematory or other wake View | as stane ! | | 08/94 | | ation - ce | - | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEHSEE 22. HAME AND ADDRESS OF FACILITY Eckhardt Funeral Chapel | | | | | | | | | | 21 | |
| _ | ahock, or ha IMMEDIATE CAUSE (Fin disease or condition reaulting in death) | eart fallure. Iai | a. Gcutt | Myo | h lina. | in and | mode of dying, au | | _ | | | Approxim Interval B |
| IFICATION | ahock, or ha IMMEDIATE CAUSE (Fin disease or condition resulting in death) Sequentially list conditi if any, leading to immed cause. Enter UNDERLY! CAUSE (Disease or inju- that initiated events | ions, diate | a. Cuttuble DUE TO b. DUE TO c. | OR AS A CO | ccuyoco | inland | mode of dying, au | | _ | | | Approxim Interval B |
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| : MEDICAL C | ahock, or his IMMEDIATE CAUSE (Fin disease or condition resulting in death) Sequentially list condition in the cause. Enter UNDERLY! CAUSE (Disease or injust that initiated events resulting in death) LAST PART II. Other significant in the cause of th | lons, diate NG ry | a. Ccutt. DUE TO b. DUE TO c. DUE TO d | (OR AS A CO | ONSEQUENCE OF) not resulting in | t enter the | mode of dying, au | n Part I. | 24s. WAS AN PERFORI | AUTOPSY MED? | 24b. | Approxim Interval B Onset and Onset and Were Autropsy F AMILABLE PRIOR COMPLETION OF G |
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| ETED BY PHYSICIAN: MEDICAL C | ahock, or ha IMMEDIATE CAUSE (Fin disease or condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition if any, leading to immed cause. Enter UNDERLYII CAUSE (Disease or injuithat initiated events resulting in death) LAST PART II. Other significat Al 2 Carres 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 1 2 Accident 3 Suicide 6 6 4 Homicide 29a. CERTIFIER (Check only) | Int condition O MEDICAL Pending investigation Could not be determined IFFING PNYS ICAL EXAMINE F PERSON WITH | a. CLUTL DUE TO b. DUE TO c. DUE TO d | OR AS A CO | onsequence of) onsequence of) onsequence of) onsequence of) onsequence of) not reaulting in ent 3 □ DOA □ 28b. Time inJu At home, farm, sto | ot enter the | woode of dying, automotion with the second state of DEATH (C) B. PLACE OF DEATH (C) Nome 5 Residence NOMK? NO VES 2 NO NO NO NO deta and place, and due D. R. S. PLACE OF DEATH (C) L. D. S. PLACE OF DEATH (C) D. S. PLACE OF DEATH (C) No NO NO NO D. S. PLACE OF DEATH (C) No NO NO NO D. PLACE OF DEATH (C) No NO NO NO D. PLACE OF DEATH (C) No NO NO NO D. PLACE OF DEATH (C) No NO NO NO D. PLACE OF DEATH (C) No NO NO NO D. PLACE OF DEATH (C) No NO NO NO D. PLACE OF DEATH (C) No NO NO NO D. PLACE OF DEATH (C) No NO NO NO D. PLACE OF DEATH (C) No NO NO NO D. PLACE OF DEATH (C) No NO NO NO D. PLACE OF DEATH (C) NO NO NO NO D. PLACE OF DEATH (C) NO NO NO NO D. PLACE OF DEATH (C) NO NO NO NO D. PLACE OF DEATH (C) NO NO NO NO D. PLACE OF DEATH (C) NO NO NO NO D. PLACE OF DEATH (C) NO NO NO NO D. PLACE OF DEATH (C) NO NO NO D. PLACE OF DEATH (C) D. PLACE OF DEATH (C) NO NO NO D. PLACE OF DEATH (C) D. PLACE OF | heck only one 1 Part I. 2 Determined to the cause to the cause time, data | 24a. WAS AN / PERFORM 1 YES 2- (Specify) CRIBE NOW IN (TION (Street as r Town, State) | AUTOPSY MED? NO NUMBER OCCU IJURY OCCU Ind Number of the 129d, DATE 129d, | 24b. IRED r Rural Ro | WERE AUTOPSY F AMILABLE PRIOR OF DEATH? 1 YES 2 1 |

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| | | ermit. Pages 1, 2, 3 should |
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| BALTIMORE, MARYLAND 21215-0020 | d withlift wours after death. Page 6 may be retained by the hospital or attending physician. | in the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should |
| BALTI | nours after death. P. | ed in by the funeral |
| ,09, | d within | impletely filled in by the |

DIVISION OF VITAL RECORDS, P.O. BOX 687

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| CPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Frouns after death. Page 6 | AMERAL OIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direct | |
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| | 1 - STATE STATE OF MARYLAND / DEPARTME CERTIFICA | NT OF HEALTH AND I | MENTAL HYGIENE REG. NO. | | | | | | | |
|---|---|---|--|--|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) Clara Catherine Wernis | 3 | 2. DATE OF DEATH DAY | year 3. TIME OF DEATH 4:56 D M | | | | | | |
| | 215-07-2190 1 M 2 XF 80 YRS. MONT | DER 1 YEAR IF UNDER 24 HRS. IS DAYS HOURS MIN. | UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 10/05/13 Maryla: | | | | | | | |
| TOR | 98. FACILITY NAME (If not institution, give street and number) 98. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF Baltimore | | | | | | | | | |
| DIRECTOR | 40 AWARD | N OR LOCATION | | 10d. INSIDE CITY | | | | | | |
| | Maryland | Baltimo | | 1 XYES 2 NO | | | | | | |
| FUNERAL | 417 Homeland Avenue | | | USA | | | | | | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 YO NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPAN If yes, specify Cuben, Mexicer 1 YES 2 NO Specify | IC ORIGIN? (Specify Yea or No— | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | |
| COMPLETED | Elamentary/Secondary (0-12) College (1-4 or 5+) #fe. Do NOT use retire | ne during most of working | 16b. KIND OF BUSINESS/IND | DUSTRY | | | | | | |
| OMP | 3 Artist 17. FATHER'S NAME (First, Middle, Last) | Laurence | | yed/Painting | | | | | | |
| BE CC | Stephen Cawarski | | ME (First, Middle, Meiden Surname) Anna (last nar | me unavailable) | | | | | | |
| TO B | 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDR | ESS (Street and Number or Rural R | oute Number, City or Town, State, Zip | Code) | | | | | | |
| | 20e. METHOD OF DISPOSITION | eland Avenue | DATE 200 LOCATION | , MD 21212-3823 | | | | | | |
| 3 | 1 Buriel 2 X Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify) Metro Cremation | ory, Inc. (| 09/06 Baltime | ore, MD | | | | | | |
| 211111111111111111111111111111111111111 | 21. SIGNATURE OF FUNERAL SEMBORISMENT CHORNALD CI | emation Soc | ciety of Mar Rd. Baltim | yland, Inc. | | | | | | |
| ATION | 23. PART I. Enter the diseases, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. iMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | ter the mode of dying, such trial Fibri Lan acc | as cardiac or respiratory arr | rest, Approximsta Interval Between Onset and Desth | | | | | | |
| CERTIFICATION | CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | |
| A | PART ii. Other significant conditions contributing to death but not resulting in the | underlying cause given in F | Part I. 24s. WAS AN AUTOPSY | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO | | | | | | |
| PHYSICIAN: MEDIC | | | 1 U YES 2 NO | COMPLETION DF CAUSE OF DEATH? | | | | | | |
| Σ | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO UNCERTAIN | | 1 TES 2 NO | | | | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | ck only one) | | | | | | | | |
| HYS | 1 1 1 1 1 1 1 1 1 1 | fursing Home 5 Residence to | 3 Other (Specify) 28d. DESCRIBE HOW INJURY OCC | CURED | | | | | | |
| B | 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could each 28 PLACE OF INJURY — At home, term, street, i | WORK? | 281. LOCATION (Street and Number | | | | | | | |
| TED | 4 Homicide determined building, etc. (Specify) | 1,42,422 | City or Town, State) | or rural noute number, | | | | | | |
| COMPLET | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the one) 2 MEDICAL EXAMINER: On the beat of examination and/or investigation, in m | | | | | | | | | |
| TO BE 0 | 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | 29c, LICENSE NUMI | 99d. DATE ≥9d. DATE > 09 | 9/06/94 | | | | | | |
| | Kevin Schendel, M.D. 560\Loch Rave | en Blvd. Bal | timore. MD 2 | 21239 | | | | | | |
| | 31. DATE FILED (MONTH, Day, Your) SEP U / 1994 Julia Danisen Russel | | | | | | | | | |



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| HOSPITA HE BUNERA HIGH TO HIGH TE | AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 2 hours after death with the State Dept, of Health and Mental Hypiene prior to burial, cremation, or removal. | I flem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|--|--|
| The same Co | HIGSPITAL OR ATTENDING | ET WERAL DIRECTOR: After deat | MANT: If Item 28 Is m |

| - 1 | 1. DECEDENT'S NAME (First, Middle, Last) | 0 3 | Ca | | ne D. | F DEATH | 2. DATE OF DEAT | | 3. TIME OF DEATH |
|------|--|--|--|---|--|--|--|--|--|
| 1 | Catherine | 0,21 | | | | | 9 | 5 | 94 7 am |
| | 4. SOCIAL SECURITY NUMBER 220-34-5521 | 5. SEX | 6. AGE (In yrs. last) | | ONTHS DAY | | (Month, Day, Yes | er) | a. BIRTHPLACE (State or Foreign |
| į | Se. FACILITY NAME (If not institution, give str | | 100 | | h CITY TOW | N OR LOCATION O | 1/29/0 | | UNTY OF DEATH |
| | Citizens Nors | sing H | one | 1- | Jaure | 1 4 | ace, ms |) Ho | reford |
| | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | | 10c. CITY, 1 | TOWN OR LO | CATION | | | 10d, INSIDE CITY |
| | Maryland - | | | | Balti | more | | | 1 PYES 2 NO |
| | 1973 N. Coll | ington A | ve. | | | 101. ZIP CODE 212] | .3 | 10g. CI1 | TIZEN OF WHAT COUNTRY? |
| | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | | TEVER IN U.S. ARM YES 2 TONG THE OR DATES | | If yes, | | SPANIC ORIGIN? (Specification, etc.) sectly: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| | 15. DECEDENT'S EDUC (Specify only highest grade of | ATION completed) | (Give | e kind of won | BUAL OCCUPA k done during | TION most of working | 18b. KIND OF | F BUSINESS/IN | DUSTRY |
| | Elementary/Secondary (0-12) | College (1-4 or 5 + | Ma I | Do NOT use r | sewif | | 1960 | Home | |
| | 17. FATHER'S NAME (First, Middle, Last) Paul Wies | ner | | | | 16. MOTNER'S | NAME (First, Middle, Me therine | Voleck | у |
| | 19a. INFORMANT'S NAME (Type/Print) Robert P. Zill, S | on | 19b. | MAILING AT | Othel | t and Number or Ru | Bel Air, | r Fown, Stere, Zi MD 210 | ip Code) 15 |
| | 20a. METNOD OF DISPOSITION 1 Duriel 2 Cremetton 3 Remo 4 Donetton 5 Other (Specify) | val from State | 20b. PLACE AN | ND DATE OF | disposition | Name of | | | - City or Town, State re Co., MD |
| - 11 | THE PROPERTY OF THE PARTY OF TH | | | | | | | | • |
| | 21. BORATURE OF FUNERAL SERVICE LICE | unda | ule | | Bru 140 | AND ADDRESS OF Zdzinski 7 Easter | Funeral I | Home Pa | A re. MD 21221 |
| | 23. PART I. Enter the diseases, or conshock, or heart fellure. LIMMEDIATE CAUSE (Finel disease or condition resulting in death) | omplications that | t caused the dear | nth. Do not | 22. NAME Bru 140° | AND ADDRESS OF Zdzinski 7 Easter | Funeral I | Home Pa | A re. MD 21221 |
| | 21. PART I. Enter the diseases, or conshock, or heart fellure. L. IMMEDIATE CAUSE (Finel disease or condition | DUE TO | t caused the dear se on each line. | UENCE OF): | 22. NAME Bru 140° | AND ADDRESS OF Zdzinski 7 Easter | Funeral I | Home Pa | A re. MD 21221 rreat, Approximata interval Betw |
| | 23. MART I. Enter the diseases, or conshock, or heart fellure. L. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events | DUE TO | COR AS A CONSEOL | UENCE OF): | 22 NAME Bru 140° enter tha i | AND ADDRESS OF ZCZINSKI ZCZINSKI ZESTER TOOLE OF dying, | PACLITY Funeral I | Home Pa | Are. MD 21221 rreat, Approximata interval Betwoonset and Do |
| | 23. WAS CASE REFERRED TO MEDICAL IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST | DUE TO | COR AS A CONSEOL | UENCE OF): | 22 NAME BRU 140° enter tha I | AND ADDRESS OF ZCZINSKI ZCZINSKI ZESTER TOOLE OF dying, | FACILITY Funeral I In Ave. Be Buch as cardiec or r Conclusion Co | Home Paltimorespiratory and Alexander San Autopsy Reformed? | A re . MD 21221 rreat, Approximata interval Betw Onset and Do Onset a |
| | 23. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Enter the diseases, or conshock, or heart fellure. Let it it it it it it it it it it it it it | DUE TO DUE TO Contributing to HOSPITAL: Inpetient 2 | t caused the dear se on each line. MAYO CO (OR AS A CONSEOU OR AS A CONSEOU OR AS A CONSEOU DEATH OF THE CONSEOU | UENCE OF): UENCE OF): UENCE OF): | 22, NAME BRU 140° enter that I would be underly with a winderly with a second s | AND ADDRESS OF ZdZinski ZdZins | in Part I. 24a. WA. (Check only one) | Home Paltimo: respiratory and SAN AUTOPSY REORMED? ES 2 NO | 24b. WERE AUTOPSY FINDMANIABLE PRIOR TO COMPLETION OF CAUSOF DEATH! |
| | 23. WAS CASE REFERRED TO MEDICAL EXAMINER? 24. WAS CASE REFERRED TO MEDICAL EXAMINER? 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. WAS CASE REFERRED TO MEDICAL EXAMINER? 27. MANNER OF DEATN 1 Netural 5 Pending investigation | DUE TO DUE TO DUE TO Contributing to Contributing to Contributing to Contributing to Contributing to Contributing to Contributing to | t caused the dear se on each line. WAY OC (OR AS A CONSEOL (OR AS A CONSE | UENCE OF): UENCE OF): UENCE OF): 200. TIME C | 22, NAME BRU 140° enter that the underly when the underly | AND ADDRESS OF ZdZinski ZdZins | In Part I. 24a. WA. PEI (Check only one) 28d. DESCRIBE N | SAN AUTOPSY REFORMED? SES 2 NO OW INJURY OC | A re MD 21221 Treat, Approximata interval Betw Onset and Da Approximate interval Betw Onset and |
| | 23. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 Yes 3 Yes 4 Yes 3 Yes 4 Yes 4 Yes 4 Yes 4 Yes 4 Yes 4 Yes 4 Yes 5 Yes 4 Yes 4 Yes 5 Yes 4 Yes 4 Yes 5 Yes 4 Yes 5 Yes 4 Yes 5 Yes 4 Yes 5 Yes 6 | DUE TO DUE TO DUE TO DUE TO Contributing to Contributing to ACCORDANCE OF (Month, Dr. 28e. PLACE OF 28e. PLA | Caused the dear se on each line. WAY OF CONTROL OF AS A CONSEQUENCE OF AS A CONSEQUEN | UENCE OF): UENCE OF): UENCE OF): 200. TIME C | 22, NAME BRU 140° enter that the underly when the underly | AND ADDRESS OF ZdZinski ZdZins | In Part I. 24a. WA. PEI (Check only one) 28d. DESCRIBE N | Home Paltimo: respiratory as SAN AUTOPSY REORMED? ES 2 NO OW INJURY OC treet and Number | 24b. WERE AUTOPSY FINDMANIABLE PRIOR TO COMPLETION OF CAUSOF DEATH! |

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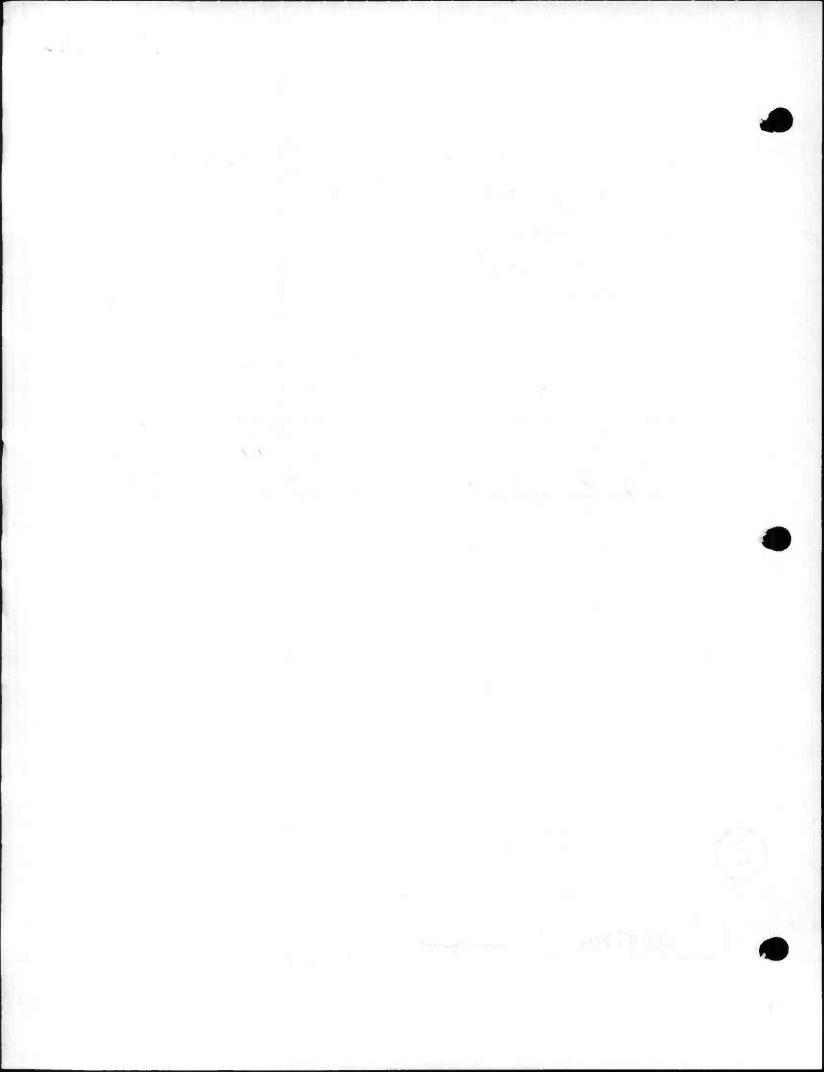
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FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

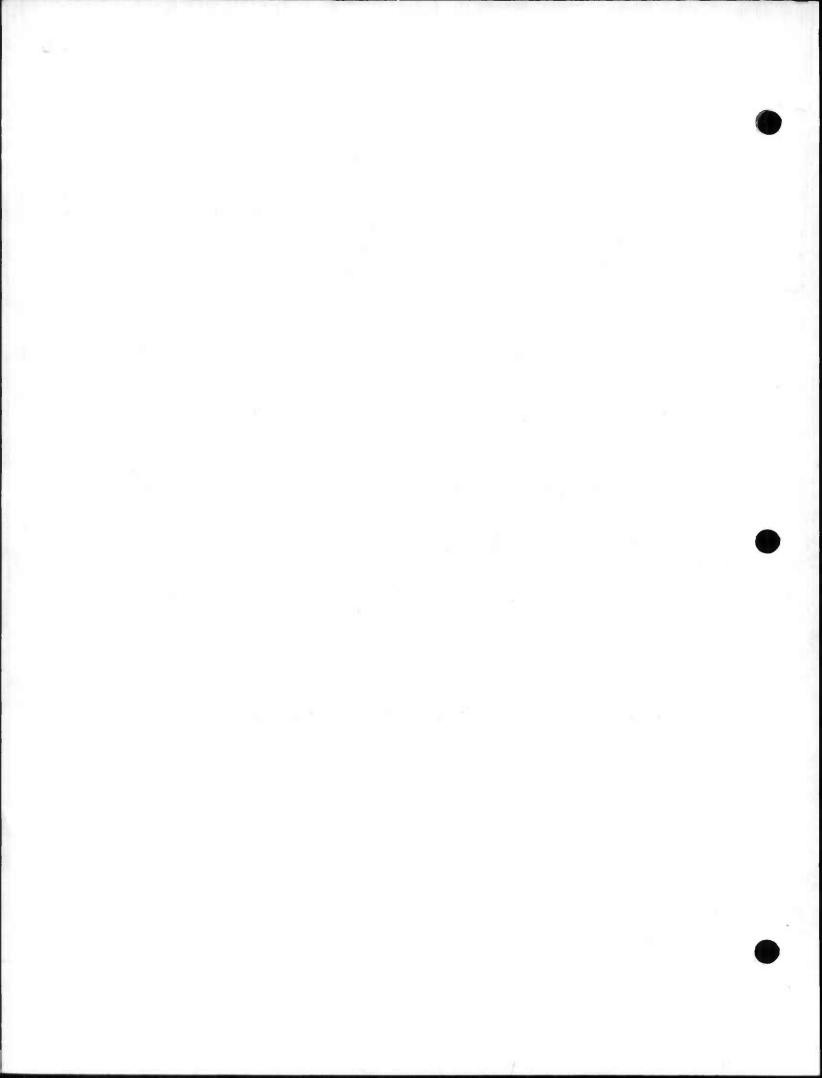
| | 1. DECEOENT'S NAME (First, | Middle, Last) | | | | | | | | T | 2. DATE OF | DEATH | - | | 3. TIME OF DEATH |
|---------------|---|-------------------------------|--------------------------------|--------------|-------------------|--------------------|---|--------------------|----------|----------|---|-------------------|------------------------|-----------------------------|--|
| | HILDA | INKHA | N | | | | | | 9/5/9 | 94 | A. | YEAR | 4:45 am M | | |
| | 4. SOCIAL SECURITY NUME | | 5. SEX 1 | | yrs. last birthde | MONT | NOER I YEA | _ | ER 24 HF | RS. | 7. DATE OF I | SIRTH v. Year) | | 8. BIRTH | IPLACE (State or Foreign |
| | 218-03-2006 | 7 | 4 YRS | 3. | | | | | NOV . | 4, 1 | 919 | MAR | LAND | | |
| œ | 9a. FACILITY NAME (If not in | mp. | - | | N OR LOCA | 317-25 | F DEA | TN | | | NTY OF D | | | | |
| 2 | GREATER BALTIMORE MEDICAL CENTER | | | | | BALTIMORE BALTIMOR | | | | | | | TORE | | |
| DIRECTOR | 10a. STATE 10b. COUNTY | | | | | | LIMIT | | | | | | | 10d. INSIDE CITY LIMITS? | |
| | MARYLAND BALTIMORE | | | | | | ON | | | | | | | | 1 TES 2 NO |
| R | 10e. STREET AND NUMBER | | | | | | | 101. ZIP CC | | | | | 10g. CI1 | | WHAT COUNTRY? |
| FUNERAL | 32 DUNVALE | ROAD A | APT. 103 | T Puen In 11 | 0.101100 | | | | 1204 | | | | | | JSA |
| | 1 Never Married 2 | Married | FORCES? 1 | YES : | 2 XNO | | If yes, | specify Cu | ben, Me | exicen, | Puerlo Rica | | or No- | | E — American Indian, k, White, atc. |
| В | 3 Widowed 4 Divo | rced | ii res, dive v | AN ON DAIL | .5 | | 1 📙 🕈 | ES 2X N | 0 5 | респу: | | | | Swi | TITE |
| COMPLETED | | EDENT'S EDUC highest grade | | 16 | Give kind | of work di | lone during | TION most of wo | king | | 16b, KIN | D OF BUS | SINESS/IN | DUSTRY | |
| ٦ | Elementary/Secondary (0 | 1-12) | College (1-4 or 5+ | -) | IIIe. Do NO | | WIFE | | | | | | ат н | OME | |
| MC | 17. FATHER'S NAME (First, M | iddle Lest) | | | п | OUSE | MILE | | THEO | CNAMI | E (First, Midd) | | | OFILE | |
| | PARKER | V | VILSON | С | COOK | | | - 1 | SSI | | E (r not, middi | | EARL | | FISCHER |
| TO BE | 19a. INFORMANT'S NAME (7 | | | | 19b. MAIL | INO ADDI | RESS (Street | et and Num | er or R | tural Ro | ute Number, (| Hy or Tow | n, State, Zi | p Code) | |
| ۴ | WILLIAM ROE | | NKHAN | | 32 | DUNV | ALE | ROAD | AP | r. | 103 Т | OWSO | N, M | D. 2 | 1204 |
| | 20a. METHOD OF DISPOSITION 1 M Burlal 2 Cremation 4 Dominion 5 Comments | n 3 🗆 Remo | oval from State | | ACE AND DA | | | | | 9/ | 9/94 | | | City or To | |
| 1 | 21. SIGNATURE OF FUNERAL | | | | | | | | ESS O | | 1 " | | | | • |
| | Soln, | 60 | alan | E. DO | LAN | | 22. NAME AND ADDRESS OF FACILITY RUCK TOWSON FUNERAL HOME INC. 1050 YORK ROAD TOWSON, MD. 21204 | | | | | | | 04 | |
| \neg | 23 PART I. Enter the di | seases, or c | omplications that | coused th | ne death, D | o not er | | | | | | | | | Approximate |
| | IMMEDIATE CAUSE (Fin | | List only one csu | se on escr | n line. | | | | | | | | | | interval Between Onset and Death |
| | disease or condition resulting in death) | + | Pneumor | nia | | | | | | į | | | 1 week | | |
| | | | | | ONSEQUENCE | OF): | | | | | | | | | years |
| CERTIFICATION | Sequentially list conditi | | Cor Pu | OR AS A CO | ONSEQUENCE | OF); | | | | | | | | | Jears |
| S | if any, leading to immed cause. Enter UNDERLY! CAUSE (Disease or Inju | NG | | | | | | | | | | | | | |
| E | that initieted events resulting in death) LAS | 1 | OUE TO | OR AS A CO | CONSEQUENCE OF): | | | | | | | | | | |
| H | resulting in death) LAS | | ı, | | | | | | | | | | | | |
| | PART II. Other aignifica | nt condition | contributing to | deeth but | not resultin | g in the | underly | ing ceus | given | n in Pi | Part I. 24s. WAS AN AUTOPSY PERFORMED? | | | 24b. | WERE AUTOPSY FINDINGS |
| MEDICAL | | | | | | | _ | | | | _ 10 | | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| ME | | | | | | | | | | | | 1 TES 2 NO | | | |
| Ä | | | | | | | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 YNO | MEDICAL | HOSPITAL: | | | | HER: | PLACE OF | | | | | | | |
| ¥ | 27. MANNER OF DEATN | | 1 N Inpatient 2 26e. OATE OF | INJURY | | TIME OF | _ | NJURY AT | Residen | | Other (Sp | | (y) NOW INJURY OCCURED | | |
| ВУР | | Pending investigation | (Month, Oa | ly. Year) | | INJURY | | WORK? YES 2 | □ NO | - 1 | | | | | |
| 311 | 3 Sulcide 6 | Could not be | 28e. PLACE Of building, | F INJURY | At home, terr | n, atreet, | factory, of | fice | | 2 | ef. LOCATIO | | nd Numbe | r or Rural F | Poute Number, |
| COMPLETED | | fetermined | | | | | | | | | , | orallo, | | | |
| APL | | | CIAN: To the best of | | | | | | | | | | | | |
| 8 | 2 MEOI | | | amination en | nd/or investig | ntion, in r | my opinion | , death occ | ured at | the tin | ne, deta and | piaca, an | d due to t | ha ceuse(a |) and menner as stated. |
| BE | 296. SIGNATURE AND TITLE | OF CERTIFIER | | -0 | , | | | | 003 | | ER | | | 9/6/9 | (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF | | | | | | | | | _ | | | | -1 -1 0 | |
| | Nathan A. Du | | | | | | | reet | To | WS | on, M | 212 | 204 | | |
| | 31. DATE FILED (MOTIN DE) | 94 | 32. REGISTRAI | R'S SIGNATU | IRE | | | | | | _ | | | | |
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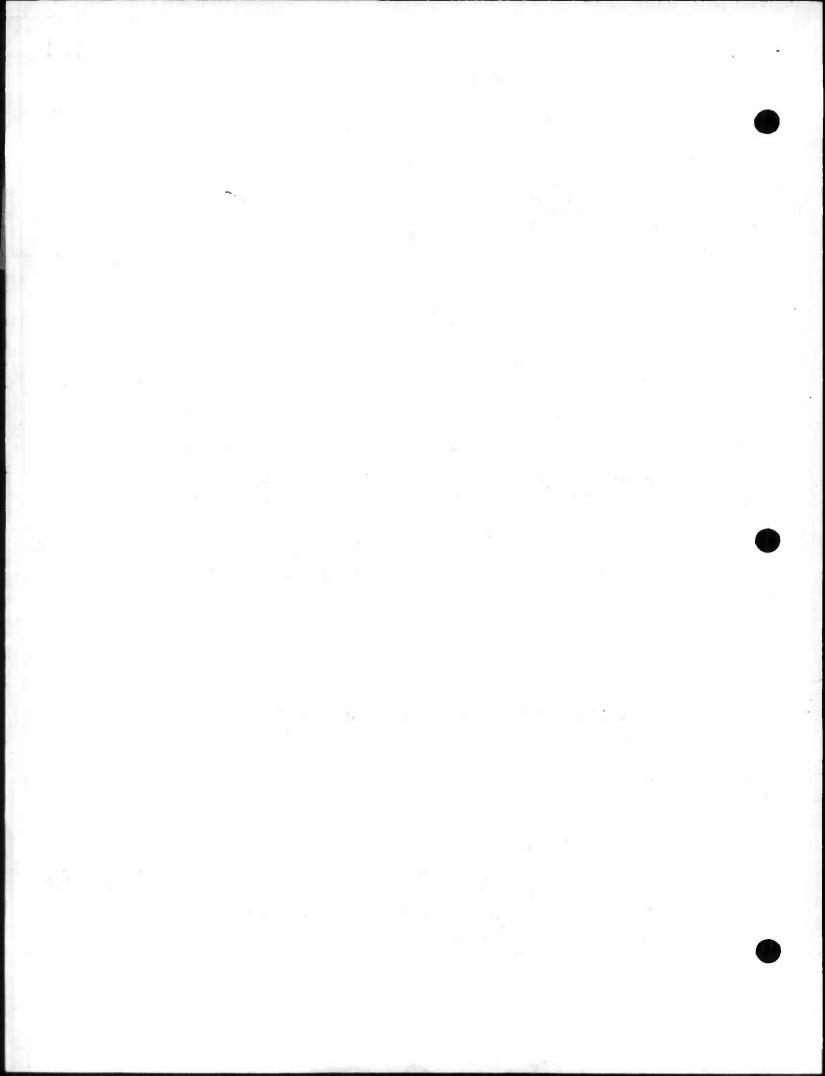
| | | FOR STATE REGISTRAR | STATE OF MA | | | | | EALTH ANDEATH | | ENTAL HYGIE! | | | |
|---|---------------|--|--------------------------------|--------------------|-------------------|--------------------|----------------------|--------------------------|----------------|---|---------------------|--|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | _ | | | 2 | | DAY YE | 3. TIME OF DEATN | |
| | | Janice E. 4. SOCIAL SECURITY NUMBER | Zeeler 5. sex | 6. AGE (In yrs. la | at blethelms | IF UNDER 1 | vr.a I | IF UNDER 24 H | | DATE OF SHITTH | 4 94 | | |
| | | 219-40-5399 | 1 □ M 2 🛣 F | 50 | YRS. | MONTHS | DAYS | | RIN. | (Month, Day, Year) 9/27/43 | 8. B | IRTNPLACE (State or Foreign ountry) Maryland | |
| pinous | | 9a. FACILITY NAME (If not institution, give s | treet end number) | | | 9b. CITY, | TOWN O | R LOCATION (| | | 9c. COUNTY | | |
| 2,3 | СТОВ | Harbor Hospital | Center | | | Ba1 | Ltim | ore | | | ===== | | |
| Pages 1. | Di l | 10e. STATE 10b. COUNTY | 1 | | 10c. CIT | Y, TOWN OF | R LOCATI | ION | | | | 10d, INSIDE CITY | |
| | DIRE | | Arundel | | G1 | en Bu | ırni | е | | | | 1 YES 2 NO | |
| ut permit. | FUNERAL | 100. STREET AND NUMBER 107 G Governor's | Court | | | | | 21061 | | | 10g. CITIZEN | DF WHAT COUNTRY? | |
| 020 physician. burlal-transit | UNE | 107 G Governor's | 12. WAS DECEDENT | | | 13. W | | | IISPANIC | ORIGIN? (Specify Y | e or No 14, | RACE — American Indian. | |
| | B₹ | 1 Never Merried 2 Merried 3 Wildowed 4 Divorced | FORCES? 1 FYES, GIVE WA | | NO | - It | yes, spe | cify Cuben, M | | Puerto Rican, etc.) | 2 4-30 | Black, White, etc. Specify: White | |
| 21 arte | 딢 | 15. DECEDENT'S EDU (Specify only highest grade | | (0 | Give kind of | USUAL OC | CUPATID uring mos | N st of working | | 16b. KIND OF BI | RY | | |
| Q = 15 | PLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | lih | Bus Driver Hubers | | | | | | Bus Service | | |
| AND the hospital detached for | COMPL | 12th Grade 17. FATHER'S NAME (First, Middle, Last) | | | bus L | TIVEL | | 18. MOTHER | 'S NAME | (First, Middle, Meide | | TAICE | |
| # & & Z | TO BE C | William I. Smeltzer Doris E. Shilow | | | | | | | | | | | |
| MA retain 5 sho | | 196 INFORMANT'S NAME (Non-Print) | | | | | | | | | | 21061 | |
| IMORE, Page 6 may be If director, page | | 20e. METNOD OF DISPOSITION TEXTS and 1 Comments 1 Comments 1 Comments 2 Comm | oval from State | cemetery, cr | ematory or o | | N COS IN | | | | OCATION — City | | |
| Page 6 ma al director, p | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Cedar Hill Cemetery 9/7 Baltimore, Maryland 22. NAME AND ADDRESS OF FACILITY Gonce Funeral Home | | | | | | | | | | | |
| BALTIN ter death. Pag the funeral di wal. | | Kukacd | - EX | laves | 0 | 400 | 01 R | itchie | e Ho | wy, Balt | | | |
| # > E 3 | | 23. PART I. Enter the diseases, or o shock, or heart failure. | complications that | caused the d | eath. Do i | not enter | the mod | de of dying, | , such a | na cardiac or rea | piratory arreat, | Approximate | |
| filled in bion, or rer | | shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition | | | | | | | | | | | |
| d with ompletely 1, cremati event, t | | esulting in death) a. Itastt Cecument Cardin and Herry. DUE TO JOR AS A CONSEQUENCE OF: | | | | | | | | | | | |
| | N | Sequentially list conditions, The Polyman As A consequence by | | | | | | | | | | | |
| rate pe | CERTIFICATION | If any, leeding to immediate cause. Enter UNDERLYING | | | | | | | | | | | |
| certificate ding physi hygiene pr | FI | CAUSE (Disease or Injury that initieted events DUE TO (OR AS A CONSEQUENCE DF): | | | | | | | | | | | |
| L = 5 = 0 | H | resulting in death) LAST | | | | | | | | | | | |
| 0 65 5 | A | PART II. Other aignificant condition | s contributing to d | leath but not | resulting | in the und | derlying | cause give | en in Pa | | N AUTOPSY ORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | |
| res that signed by teatth are sany | MEDIC | | | | | | | | | _ 1 _ YES | | COMPLETION OF CAUSE OF DEATH? | |
| required by H Legal | | DID TODA CCO HAT | | | | | | | | | | 1 TYES 2 ND | |
| AL he law has Depr | SICIAN: | DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL | CONTRIBUTE | : IO CA | USE O | F DEA | | ACE OF DEAT | NO N (Check | | | | |
| VII A MAN: The rtificate h he State or item | rsic | EXAMINER? | HOSPITAL: 1 Inpatient 2 I | ER/Outpatient | 3 12 DOA | OTHER 4 Nursi | | e 5 🗆 Reelde | ence 8 | Other (Specify) | | | |
| D PHYSIC S. | Y PHYS | 27. MANNER DF DEATN 1 Natural 5 Pending Investigation | 26e. DATE DF II (Month, Day | | 26b. TIN | IE OF JURY M | | URY AT RK? /ES 2 N | - 1 | 8d. DESCRIBE NOW | INJURY OCCURE | D | |
| SION (C | 200 | 2 Accident Investigation 3 Suicide 6 Could not be 4 Nomicide determined | 26e. PLACE OF building, et | INJURY — At h | ome, ferm, | street, facto | ery, office | | 2 | est. LOCATION (Stree City or Town, State | | ural Route Number, | |
| PAL OF | PLE | 290. CERTIFIER (Check only | | | | | | | | | | | |
| THE HOSPITAL THE FUNERAL filed within 72 PORTANT: II | COMPL | | | amination and/or | Investigation | on, in my op | olnion, de | eath occured a | at the tin | ne, date end place, s | and due to the ce | use(e) end menner se stated. | |
| TO THE HOSPIT TO THE FUNERA De filed within 7 | H | 296. SIGNATURE AND TITLE DE CERTIFIE AUUlle | Spr la | i | | | | 29c, LICENS | OG | 37 | 29d. DATE \$10 | S-94 (Month, Day, Year) | |
| | 5 | 30. NAME AND ADDRESS OF PERSON WH | SYUM / | DF DEATH (ITE | EM 27/(Type | Print) | Fer | Bell | d. | Mad Co | iter se | willion (bot | |
| | | SEP 0 (1994 | 32. REGISTRAR | S SIGNATURE | / | // | | | | | | . , (, , , , , , , , , , , , , , , , , | |
| | | U. | | | | | | | _ | | | DNMH-16 Rev 1/8 | |



FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1 - STATE REGISTRAR | | C | ERTIF | ICATE O | DEATH | F | REG. NO. | | | | |
|---------------|--|---------------------------|---------------------------------|---------------|--------------------------|--|------------------|-------------------------------|--|--|--|--|
| Į. | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF | DEATH | | 3. TIME OF DEATH | | |
| ij | John | Eugene | | A | rcher, | Sr. | Augu | st 3, | 1994 | 2:52 P | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (In yrs. la | | IF UNDER 1 YEAR | | 7. DATE OF | BIRTH | 9. BIRTI | HPLACE (Stete or Foreign | | |
| | 290-36-1919 | 1 🙀 M 2 🗌 F | 53 | YRS. | MONTHS DAYS | HOURS MIN. | Nov 1 | 6, 194 | 10 Count | n) 10 | | |
| | 9e. FACILITY NAME (If not institution, give s | treet end number) | | | 9b. CITY, TOWN | OR LOCATION OF D | EATN | 94 | DEATH | | | |
| DIRECTOR | 187 Lighthouse R | oad | | | Piney | Point | | St. Mary's | | | | |
| JE | 10e. STATE 10b. COUNT | | | | Y, TOWN OR LOC | ATION | | | 10d. INSIDE (| | | |
| | | Mary's | | Ca. | llaway | | | | | 1 TYES 2 NO | | |
| FUNERAL | P.O. Box 8 | | | | | or. ZIP CODE 20620 | | 10 | U.S.A | WHAT COUNTRY? | | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. AI | | | CENDENT OF HISPA | | | No- 14. RAC | 4. RACE — American Indian, | | |
| BY | 1 Never Merried 2 Merried 3 Widowed 4 Divorced | IF YES, GIVE W | | NO | | specify Cuban, Mexic S 2 X NO Speci | | n, etc.) | c.) Black, White, etc. Specify: White | | | |
| ED | 15. DECEDENT'S EDU (Specify only highest grade | CATION Completed) | | | USUAL OCCUPA | | 16b. KIP | D OF BUSINE | SS/INDUSTRY | | | |
| | 12th Grade | College (1-4 or 5 + | life | a. Do NOT u | se retired.) | nost or working | | | | | | |
| COMPLETED | | | | FTEC. | trician | | U | .S. Na | ivy | | | |
| 00 | 17. FATHER'S NAME (First, Middle, Lest) William | Wallac | 10 | Arche | 7.20 | 18. MOTHER'S NA | | | | D1 | | |
| BE | | Wallac | | | | Sophr | | | nche | Rader | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) Mary Rita Archer | | 19 | P.O. | BOX 8 | and Number or Rural Callaw | ay, Ma | chy or Town, S ryland | tate, Zip Code) l 2062 | 0 | | |
| | 20e. METHOD OF DISPOSITION | ound toom State | | | OF DISPOSITION (| | DATE | 20c. LOCAT | tON — City or To | own, State | | |
| | 1 M Burlet 2 Cremation 3 Removel from State Cemetery, crematory or other piace) Cemetery Cheltenham, Maryland Cheltenham, M | | | | | | | | | | | |
| | 22. NAME AND ADDRESS OF FACILITY Mattingley-Gardiner Funeral Home, P.A. | | | | | | | | | | | |
| Į. | Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 2065 | | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or | domplications the | t caused the de | eeth. Do | not enter tha n | node of dying, suc | ch ae cardtac | or respirate | ory arrest. | Approximata | | |
| | shock, pr heart fallure. List pniy pna cause pn each lina. IMMEDIATE CAUSE (Final Onset and Death | | | | | | | | | | | |
| | disease or condition | . () | arci | no | nalo | ver | | | | 2mx | | |
| | resulting in death) DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| z | - Carring of Luna | | | | | | | | | | | |
| E | Sequentially list conditions, if any, leading to immediate Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury | 6. | | | | 1 | |) | | V | | |
| E | that initiated events resulting in death) LAST | DUE 10 | (OR AS A CONSE | QUENCE O | 71 | | / | | | | | |
| 5 | | d. | | | | - | / | | | | | |
| 7 | PART ii. Other algnificant condition | na contributing to | death but not | reaulting | in the underly | ng causa givan ir | Part i. 24 | . WAS AN AUT | | . WERE AUTOPSY FINDING | | |
| MEDICAL | | | | | | | | PERFORME | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| Ä | | | | | | | | | | 1 YES 2 NO | | |
| ä | DID TOBACCO USE (| CONTRIBUTE | TO CAU | SE OF | DEATH | YES X NO | | | | NA | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | 26. | PLACE OF DEATH (C | heck only one) | | | | | |
| Sic | 1 YES 2 NO | HOSPITAL: | ER/Outpatient | 3 🗆 DOA | OTHER: 4 - Nursing He | ome 5 Residence | 6 Other (S) | pecify) | | | | |
| H | 27. MANNER OF DEATH | 26e. DATE OF (Month, D | | 28b. TIN | | NJURY AT YORK? | 26d. DEŞCRI | BE HOW INJU | RY OCCURED | | | |
| B | 1 Natural 5 Pending 2 Accident Investigation | | Carline. | | M 1 | YES 2 NO | | | | | | |
| | 3 Suicide 6 Could not be | 26e. PLACE O building. | F INJURY — At he etc. (Specify) | ome, ferm, | street, tactory, of | lice | | ON (Street and own, State) | Number or Rural | Route Number, | | |
| E | 4 Homtoide determined | | | | | | | | | | | |
| P | | ICIAN: To the best of | my knowledge, d | eath occur | ed at the time, de | te and place, end du | e to the cause(| e) end menner | es atated. | | | |
| COMPLETED | one) 2 MEDICAL EXAMINE | ER: On the basis of a | amination anglor | Investigation | on, in my opinion | death occured at the | e time, date end | d place, and d | ue to the ceuse(| a) end menner se stated. | | |
| | 29b. SIGNATURE AND TITLE OF CENTIFIE | n // (| 11 | 1 | 10 | 29c, LICENSE NU | IMBER | 1 / 21 | d, DATE SIGNE | O (Month, Day, York) | | |
|) BE | 4 | XX | W/1/3 | =// | 41) | 1)0 | 64 | 191 | 8- | 4-94 | | |
| 임 | 30. NAME AND ADDRESS OF PERSON WE | O COMPLETED CAU | SE OF DEATH (ITE | EM 27) (Type | , Print) | | - 1 | - | | 1-1-1- | | |
| | J. Patrick Jarbos | e, M.D./ | Leon | ardto | own, Mai | cyland 2 | 0650 | | | | | |
| | 31. DATE FILED (Month, Day, | 13 RESISTRA | ME SIGNATURE | 1.17 | | | | | | | | |
| | AUG 05 1994 | Julya dia | marties way | day | | | | | | | | |
| - 11 | AUG 05 1337 | | | | | | | | | | | |



3. TIME OF OEATH

JANE TRUM

intervai Bstween Onset and Death

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

8. BIRTHPLACE (State or Foreign Pennsylvania

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

02

rederic

AUG 2 6 1994

31. DATE FILED (Month, Day, Year)

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

Mary Katherine ADAMS

| | - | | 175-03-3256 | 5 | 1 🗌 M 2 🔀 F | 75 | | YRS. | MONTHS | DAYS | HOURS | MIN. | Aug. 1 | 5,19 | 16 | Per | nnsylvani |
|----------------|--|---------------|--|--|--|----------------|-------------|-------------|------------------------|----------|-----------------------------------|---------------------------------------|---------------------------|-------------------------------------|-------------|----------------------------------|---|
| | should | _ | 9a. FACILITY NAME (If not in | | | | | | 9b. CITY, | TOWN | OR LOCATIO | ON OF DEAT | Н | | 9c. COU | NTY OF D | EATH |
| | , c, | DIRECTOR | Washington | | y Hospita | 11 | | | | I | Hagers | stown | | | I | Vash: | ington |
| - | * | E C | 10a. STATE | 10b. COUNTY | 1 | | Т | 10c. CITY | TOWN O | R LOC | ATION | | | | | | 10d. INSIDE CITY |
| £7 | (4) | | Maryland | L | shington | 1 | | В | ager | sto | own | | | | | | 1 YES 2 NO |
| 8. | 39 | UNERAL | 10s. STREET AND NUMBER | | | | | | | 1 | of. ZIP CODE | | | | 10g. CIT | | WHAT COUNTRY? |
| | 5 8 | Ä | 807 Linwood | i Koad | | | | | | \perp | | L740 | | | L, | USA | |
| 215-0020 | attending priyses | ВУ Е | 11. MARITAL STATUS 1 Never Married 2 🔀 3 Widowed 4 Divo | | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | YES : | 2 ANO | ED) | 13. 1 | NAS OF | ECENDENT OF SPECIFIC CUBER SECOND | F HISPANIC n, Maxicon, Specify: | ORIGIN? (S Puerto Rici | Specify Yes in, etc.) | or No— | 14. RACI Black Spec Whi | |
| 21 | | 日 | | EDENT'S EDU | | 16 | (Give | kind of w | JSUAL OC | CUPAT | TION nost of working | 9 | 16b. KI | ND OF BUS | SINESS/INC | USTRY | |
| 64 | ي ي | COMPLET | Elementary/Secondary (0 | 1-12) | College (1-4 or 5 | +) | life. D | Do NOT us | retired.) tres | | | | | dres | s fac | tory | У |
| A . | be detached to | O | 17. FATHER'S NAME (First, M | liddle, Last) | | | | | | | 18. MOTH | ER'S NAME | (First, Mide | ile, Meiden | Sumame) | | |
| \mathbf{z} | 5 B B | ш | Raymond Gar | field | Morse | | | | | | -N | lancy | Jane | Win | k /\/F | NCY | / JANE TA |
| IAR | 5 should notified | TO B | 19a. INFORMANT'S NAME (| | | | 19b. | MAILING | ADDRESS | (Street | | | | per, City or Town, State, Zip Code) | | | |
| | | | Pauline Ada | | | | | 80 | 7 Li | ndv | vood R | ld., 1 | lager | stow | n, Mo | 1. 2 | L740 |
| ORE | stor, pust | | 20a. METHOD OF DISPOSIT 1 Burlal 2 Crematic 4 Donation 5 Other | n 3 🗆 Rem | oval from State | | | alory or ot | F DISPOS ner place) | ITION (| Name of | | DATE | 20c. LO | CATION — | City or To | wn, Stata |
| ME S | death. Pe funeral | | 21. SIGNATURE OF FUNEBA | 21. BIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME | | | | | | | | | | | | | |
| BAL | | | 190 | Att | 1/// | ins | KL | ek | | | | | | | gerst | own. | ,Md.21740 |
| - 7 | | | 23. PART I. Enter the d | lseeses, or o | complications the | t ceused th | e deel | th. Do n | | | | | | | | | Approximate |
| | e 2 e | | IMMEDIATE CAUSE (Final disease or condition | | | | | | | | | | | Onset and E | | | |
| 30 | poletely fille cremation, rent, the | 1 | resulting in death) e | | | | | | | | | | | | | | |
| 68760 | and completely to burial, crematic matic event, th | z | | | ь. (| Cori | 2 | ar: | 1/ | 2 | Luy | 7 | igla | a | | | |
| | CSE | E | Sequentielly list condit if any, leading to imme | diete | DUE TO | (OR AS A CO | | *** | | | | | | | | | |
| .O. BC | physicia ne prior | 5 | Cause. Enter UNDERLY CAUSE (Disease or inju | | c. DUE TO | (OR AS A CO | | | | اسر ا | 2 1 | | | | | | _ |
| P.O. | | CERTIFICATION | that initiated events resulting in death) LAS | т 📗 . | 4 | (011 70 7 00 | NOLOG | JENOE OF | ,. | | | | | | | | Ì |
| Ś | | | PART II. Other algorifica | mt condition | | death beat | | 444 | | | | | | | | | |
| ORD | and A | EDICAL | 1 | | - We t | | not re | euiting | n the un | deriyi | ng cause g | jiven in Pa | Ift i. 24 | e. WAS AN | | 246 | AVAILABLE PRIOR TO COMPLETION OF CAL |
| O | signed Health | ED | 2021)0 | ACT IV | -0001 | | | | | | | | _ 1 | YES 2 | NO | | OF DEATH? |
| RE | been f. of t | Σ: | DID TOBACO | O USE | CONTRIBUT | IF TO | A119 | SE OF | DEA | TH | YES C | 1 NO | _ | | | | 1 NES 2 NO |
| TAL | S be a | CIAN | 25. WAS CASE REFERRED T | | | | | <u> </u> | | | PLACE OF DE | | | | | | |
| VITA | certificate h the State C | S II | EXAMINER? | | HOSPITAL: | ER/Outpath | int 3 [| DOA | OTHER | | me 5 🗆 Re | sidence 8 | Other (S | pecify) | | | |
| OF | frer this certimeter with the marked, or | РНҮ | 27. MANNER OF DEATH | | 28a. DATE OF (Month, E | | | 28b. TIME | | 28c. IP | NJURY AT | 2 | 8d. DESCR | IBE HOW I | NJURY OC | CURED | |
| N | After this c death with | B | 2 Accident | Pending Investigation | | | | | М | | YES 2 | NO | | | | | |
| DIVISION OF VI | DIRECTOR: A hours after d | 8 | 3 Suicide 8 Homicide | Could not be determined | 28e. PLACE (building, | otc. (Specify) | At hom | e, lerm, s | treet, lacti | ory, off | lice | 2 | | ON (Street a fown, State) | and Number | or Rural I | Route Number, |
| 5 | DIRE Hour | PLE | 29e. CERTIFIER | TIFYING PHYSI | CIAN: To the best of | my knowleds | no dant | h occum | d at the ti | me de | de and place | and due to | the causes | e) and mad | nor on also | lad | |
| - ALIGOOM | 3 32 = | COMP | ane) | | | | | | | | | | | | | | a) and manner as stat |
| 001 | FUN WITH | U U | 296. BIGMATURE AND TITLE | | 1 // | 1 | | 1 | | | _ | NSE NUMBI | | | | | O (Month, Day, Year) |
| 4 | TO THE FUNES DE filed within IMPORTANT: | 0 8 | Juden | e / | - lle | 1 | na | 7 | | | 20 | 36 | 23 | > | • | 13 | 24/94 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

111

224

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

6. AGE (In yrs. lest birthday) IF UNDER t YEAR IF UNDER 24 HRS.

2. DATE OF DEATH

1685 2

7. DATE OF BIRTH

DHMH-18 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

Donald

A. SOCIAL SECURITY NUMBER

1. DECEDENT'S NAME (First, Middle, Last)

Bounds

5. SEX

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| DIVISION OF VITAL RECORDS, F | (|
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29

IF UNDER 1 YEAR 1 X M 2 F 215-20-1852 YRS 66 Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 8 Pickett Road Lutherville RESIDENCE OF DECEDENT 10s. STATE 10c. CITY, TOWN OR LOCATION MD. BALTIMORE LUTHERVILLE permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP COOF 8 PICKETT RD filled in by the funeral director, page 5 should be detached for use as the burial-transit 21093 Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 YES 2 NO BY Specify: 3 Widowed 4 Divorced KOREA COMPLETED 15. OECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refired.) (Specify only highest gr Elementary/Secondary (0-12) College (1-4 or 5+) TAX ACCOUNTANT be notified at once 17. FATHER'S NAME (First, Middle, Last) WOODLAND M.BOUNDS 19a, INFORMANT'S NAME (Type/Print) 2 ELEANOR BOUNDS PICKETT RD. 20b. PLACE AND DATE OF DISPOSITION (Name of must Place, cramatory or other place). examiner 21. SIGNATURE OF EDNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY removal. medical 23. PART i. Enter the diseees, or complicatione that caused the death. Do not enter the mode of dying, such as cardiac or reepiratory street, shock, or heert failura. List only one cause on each line. IMMEDIATE CAUSE (Finsi the cremation, disease or condition completely reaulting in deeth) other traumatic event, burial, CERTIFICATION and Sequentially list conditions, prior to QUE TO (OR AS A TOONSEORENCE OF If sny, lesding to immediate cause. Entar UNDERLYING 1005 C CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events attending reaulting in daeth) LAST 6 Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL Health and shows any has been s Dept. of H PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 🗆 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA 1 YES 2 NO OTHER: 4 Nursing Home 5 Residence 8 Other (Specify) 10 28s. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? marked, Natural . 5 Pending 1 YES 2 NO L DIRECTOR: After the hours after death v BY 2 Accident
3 Suicide Investigation 28e. PLACE OF INJURY — At home, farm, street, tactory, offica building, etc. (Specify) 92 COMPLETED 8 Could not be 4 Homicide 28 determined tem 29s. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and menner as stated. TO THE HOSPITAL
TO THE FUNERAL I
DE filed within 72 h
IMPORTANT: II II (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner es stated. 295. SIGNATURE AND TITLE OF CENTIFIE 29c. LICENSE NUMBER BE DZ600Z 2 PLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John H. Eppler, M.D. 120 Sister Pierre Dr. Towson, Md. 31. DATE FILED (Month, Dey, Year)
AUG 1 8 1994 12. HIGISTRAB'S SIGNATURE

CERTIFICATE OF DEATH

6. AGE (In yrs. last birthday)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO 2. DATE OF OEATH 3. TIME OF DEATH August 14 1994 6:30 A 7. DATE OF BIRTH (Month, Day, Year) 4-16-1928 IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign MARYLAND 9c. COUNTY OF DEATH Baltimore 10d, INSIDE CITY 1 YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian, Black, White, etc. Specify: BTIHW 16b. KIND OF BUSINESS/INDUSTRY ACCOUNTING 16. MOTHER'S NAME (First, Middle, Maiden Surname) LUCILLE BOUNDS LUTHERVILLE, MD. 21093 DATE 20c. LOCATION - City or Town, State SALISBURY.MD. BOUNDS FUNERAL HOME, SALISBURY, MD Interval Betwe Onset and Death MINUTES 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 - YES 2 NO 1 _ YES 2 _ NO 28d. DESCRIBE HOW INJURY OCCURED 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Qay, Year)

SKY

18

DHMH-16 Rev 1/89

Ruby Bounds

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO

| | REGISTRAR | | CERTIF | ICALE | OF DE | =AIH | REG | . NO. | | | |
|--------------|--|---------------------------------------|----------------------------------|---------------------|------------------------------|----------------|---|-----------------------------|------------------------|--------------------------------|--|
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) RUBY COX BOUNDS 2. DATE OF DEATH MONTH AND YEAR August 15, 1994 | | | | | | | | | | |
| | | | | | | | | | 94 | 2:00 | |
| | 4. SOCIAL SECURITY NUMBER | | GE (In yrs. last birthday) | IF UNDER | | UNDER 24 HRS. | 7. DATE OF BIRT (Month, Day, Y | N Har) | 8. BIRTHPI Country) | LACE (State or For | |
| | 219-07-6239 | 1 🗆 M 2 💯 F | 99 YRS. | | | - 4 | 9/5/18 | | | Maryla | |
| or I | 9a. FACILITY NAME (If not institution, give s | | | | | CATION OF D | EATH | 9c. COUNTY OF DEATH | | | |
| CTOR | Salisbury Nursing | g & Rehab. | Center | Salisbury | | | | | comic | 0 | |
| III I | 10a. STATE 10b. COUNT | Y | 10c. CI | TY, TOWN O | R LOCATION | | | | 1 | IOd. INSIDE CITY | |
| DIR | Md. Wic | omico | | Sa1 | isbui | ry | | | , | LIMITS? | |
| RAL | 10e. STREET AND NUMBER | | | | 101. ZIP | | 10g. CITIZEN | | | AT COUNTRY? | |
| ER/ | | | | | | | | | | | |
| FUNE | 11. MARITAL STATUS | 12. WAS DECEDENT EVE FORCES? 1 Y | ER IN U.S. ARMED | 13. V | NAS DECENDE | ENT OF NISPA | NIC ORIGIN? (Specify Yea or No.— 14. R an, Puerto Rican, etc.) | | | - American Indi White, etc. | |
| BY F | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR O | | | | NO Speci | | c.) | Specify: | | |
| | 2421 | I CATION | | | | | | | | | |
| ETE | 15. DECEDENT'S EDU (Specify only highest grade | completed) | 16a. DECEDENT'S (Give kind of | work done d | CUPATION luring most of t | working | 16b. KIND C | F BUSINESS/IND | USTRY | | |
| | Elementary/Secondary (0-12) | College (1-4 or 5+) | and the second second | | urino | | | | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | Halla | 1400 | laiden Sumame) | mamai | | | | | |
| | | Franklin | Cox | Cox Priscilla Twigg | | | | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | O ADDRESS | (Street and Ne | _ | Route Number, City | | Code) | | |
| 2 | Grace B. Smith | | | | | | bron, M | | | 1830 | |
| | 20e. METNOD OF DISPOSITION 14 Burial 2 Cremation 3 Rem | | 206. PLACE AND DATE | OF DISPOSI | TION (Name of | | - | c. LOCATION — | | | |
| | 4 Donation 6 Other (Specify) Hebron, Ma | | | | | | | | | | |
| | 21. SIGNATUBE-OF FUNERAL MERVICE LI | MOO- | 417. / | | | DDRESS OF FA | | | | | |
| | 1 moll | 4110 | ha | H | essic | k Fu | neral H | ome . I | 3.0. | Box 6 | |
| | Messick Funeral Home, P.O. Bo Bivalve, Maryland 21814 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, into the cause on each line. Application of the cause | | | | | | | | | | |
| | anock, or haart fellure. List only one cause on each line. | | | | | | | | | | |
| | IMMEDIATE CAUSE (Final disease or condition | | | | | | | | | | |
| | resulting in death) a | | | | | | | | | | |
| z | | | | | | | | | | 1500 | |
| ERTIFICATION | Sequentially list conditions, if any, leading to immediate | | | | | | | | | 17 | |
| 8 | cause. Entar UNDERLYING CAUSE (Disease or injury | | | | | | | | | | |
| E | that initiated events | DUE TO (OR A | AS A CONSEQUENCE O | OF): | | | | | | | |
| H | resulting in death) LAST | | | | | | | | | | |
| 07 | PART II. Other aignificant condition | na contributing to deat | th but not resulting | in the unc | darlying ceu | use given in | Part I. 24s. WAS AN AUTOPSY | | 24b. V | VERE AUTOPSY F | |
| EDICAL | | | | | | | PERFORMED? | | | MAILABLE PRIOR | |
| | | | | 1 U YES 2 DANO | | | | | | OF DEATH? | |
| 2 | | | | | | | - | | | YES 2 | |
| A | 25. WAS CASE REFERRED TO MEDICAL | | | | 26. PLACE | OF DEATH (C/ | neck only one) | | | | |
| SIC | EXAMINER? | HOSPITAL: 1 Inpetient 2 ER/ | Outpatient 3 DOA | OTHER | | Residence | 6 Other (Specif | y) | | | |
| PHYSICIAN: | 27. MANNER OF DEATN | 28a. DATE OF INJU (Month, Day, Yes | RY 28b. Till | | 28c. INJURY WORK? | | | HOW INJURY OCC | CURED | | |
| ВУ | 1 Natural 5 Pending 2 Accident Investigation | (Monda, dely, los | - IN | M | 1 YES | 2 NO | | | | | |
| ED B | 3 Suicide 6 Could not be | 28e. PLACE OF INJ building, etc. (| URY — At home, farm, Specify) | street, facto | ory, office | | 26t. LOCATION (S City or Town, | Street and Number State) | or Rural Ros | ute Number, | |
| = | 4 Homicide determined | | | | | | J, G. 10411, | | | | |
| COMPLET | 29a. CERTIFIER (Check only | ICIAN: To the best of my k | nowledge, death occur | red at the tir | me, date and | place, and dus | to the cause(s) ar | d manner as state | ed. | | |
| MO | onel | R: On the basis of exemin | | | | | | | | and menner as | |
| ECC | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | | | LICENSE NU | | | | Month, Day, Year) | |
| 0 | C/X | 7/ | - | | 1 | 229 | 3/9 | 18 | 1/3/ | 90/ | |
| 임 | 30. NAME AND ADDRESS OF PERSON WI | IO COMPLETED CAUSE OF | DEATN (ITEM 27) (Type | e, Print) | | , | - | 1 | 111 | 1 | |
| | William H. Robins | | 50 & E M | | St C | alich | TAY IN | 21004 | / / | | |
| | 31. DATE FILED (Month, Day, Year) | 32 REGISTRAR'S S | IGNATURE | ain S | C. D | allSUU | TA' MD | Z1801 | | | |
| | AUG 1 9 1994 | Julia d'inved | ear Randall | | | | | | | | |
| - 10 | DUUL I II I. I. I. I. I. I. I. I. I. I. I. I | F 1 | | | | | | | | | |

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| 1 | - | STATE REGISTRAF |
|---|------|--------------------|
| Г | 1. 0 | ECEDENT'S N |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

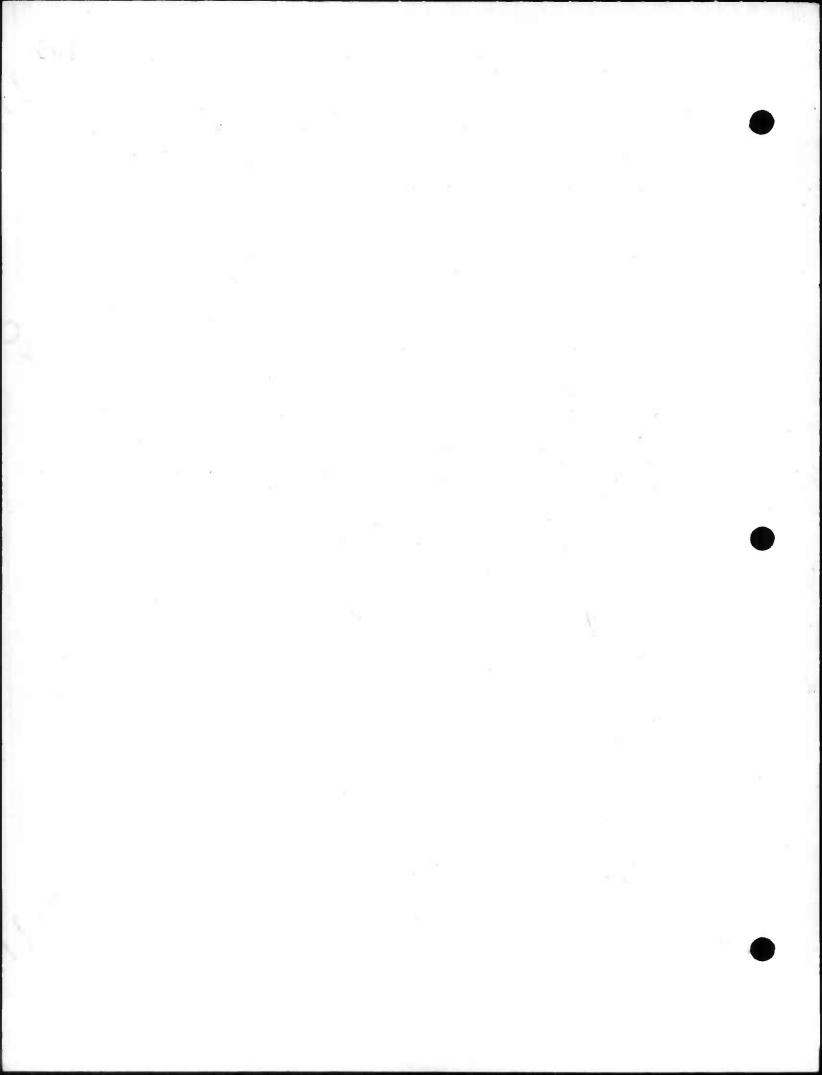
| | REGISTRAR | | CERTIFIC | ATE OF DEATH | REG. N | Ю. | | | | | | |
|--|---|---|------------------------------|--------------------------------------|---|----------------------|----------------|---|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 0 | 2. DATE OF DEATH | | | 3. TIME OF DEATH | | | | |
| | MADLYN | CATHERINE | | BAKER | AUGUST . | DAY | YEAR | 0150 " | | | | |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. last birthday) | FUNDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | XX / | | PLACE (State or Foreign | | | | |
| | 220-74-5608 | | | ONTHS DAYS HOURS MIN. | (Month, Day, Year) | 1000 | Country |) | | | | |
| | | 24 | | | August 22, | | | land | | | | |
| | 9e. FACILITY NAME (If not Institution, give st | reet and number) | • | b. CITY, TOWN OR LOCATION OF DI | EATN | 9c. COU | INTY OF DE | ATH | | | | |
| 6 | PENINSULA REGION | IAL MEDICAL | CENTER | SALISBURY | | W | COMI | CO | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT | | | | | | | | | | | |
| # | 10a. STATE 10b. COUNTY | | | OWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? | | | | |
| | Maryland Wic | omico | S | alisbury | | | | 1 YES 2 NO | | | | |
| A | 10e. STREET AND NUMBER | | | 101. ZIP CODE | IZEN OF W | HAT COUNTRY? | | | | | | |
| 8 | 209 Clay St. | | | 21801 | | US | Α | | | | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | IN U.S. ARMED | 13. WAS DECENDENT OF NISPAI | NIC OBIGIN2 (Specify | | | - American Indian, | | | | |
| | 1 Never Merried 2 Merried | FORCES? 1 TYES | 2 K NO | If yee, specify Cuben, Mexics | se, specify Cuben, Mexican, Puarto Rican, etc.) Black, White, atc | | | | | | | |
| BY | 3 X Widowed 4 Divorced | IF YES, GIVE WAR OR D | DATES | 1 YES 2 X NO Specif | y: | | Specify Whi | | | | | |
| | 15. DECEDENT'S EDUC | CATION | 16e. DECEDENT'S US | I CONTRICTOR | | | | . L E | | | | |
| 쁘 | (Specify only highest grade | | (Give kind of work | done during most of working | 16b. KIND OF | BUSINESS/INC | DUSTRY | | | | | |
| ۳۱ | Elementary/Secondary (0-12) | College (1-4 or 5+) | | | Art | | | | | | | |
| ₹ | / | | Artist | | | | | | | | | |
| COMPLETED | 17, FATHER'S NAME (First, Middle, Last) | | | 18. MOTNER'S NA | ME (First, Middle, Maid | en Surneme) | | | | | | |
| Willard Asbury Mumiord May Belle Hales | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| 2 | 2180 |) 1 | | | | | | | | | | |
| | Vaughn H. Baker | | CATION — City or Town, State | | | | | | | | | |
| | 1 Buriel 2 Cremetion 3 Ramo | oval from State C9 | b. PLACE AND DATE OF I | DISPOSITION (Name of place) | | | | rn, State | | | | |
| | 4 Donation 5 XOther (Specify) Fruit | | pringhill | Memory Gardens | | lebron | , MD | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE/LIC | ENSEE | | 22. NAME AND ADDRESS OF FA | CLITY | | | | | | | |
| - 1 | D/118 d/1 | Holloway Funeral Home | | | | | | | | | | |
| - | 501 Snow Hill Rd., Salisbury, MD 21801 | | | | | | | | | | | |
| | 23. PART i. Enter the diseases, or complications that causes the death. Do not anter the mode of dying, such as cardisc or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between | | | | | | | | | | | |
| | IMMEDIATE CAUSE (Finel | | | | | | | | | | | |
| | disease or condition Trates from the FACE (778) | | | | | | | | | | | |
| ŀ | resulting in dasth) a. MFOFFER SA CONSEQUENCE OF | | | | | | | | | | | |
| | | Anor | 21251 | LEROSIS | | | | years | | | | |
| CERTIFICATION | Sequentially list conditions, |) 1 1 C C | A CONSEQUENCE OF: | LE150212 | | | | graces | | | | |
| Ē | if any, leading to immediata cause. Enter UNDERLYING | DUE TO (OH AS | A CONSEQUENCE OF): | | | | | • | | | | |
| 5 | CAUSE (Disease or injury |). ** | | | | | | | | | | |
| 1 | that initiated events | OUE TO (OR AS | A CONSEQUENCE OF): | | | | | | | | | |
| # | resulting in death) LAST | 1 | | | | | | | | | | |
| ᄗ | DART II Oak I - III III | | | | | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other eignificant condition | s contributing to death | but not resulting in | the undariying cause givan in | Part I. 24a. WAS PERF | AN AUTOPSY ORMED? | | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | | | |
| 8 | | | | | 100 | 2 110 | - | COMPLETION DF CAUSE OF DEATH? | | | | |
| Ĕ. | | | | | | | - 1 | | | | | |
| 2 | | | | | — | | | 1 YES 2 NO | | | | |
| A | or the case persons to tenion. | | | | | | | | | | | |
| Ö | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL | | 26. PLACE OF DEATN (Ch | eck only one) | | | | | | | |
| Z. | 1 TES 2 NO | 1 mpatient 2 ER/Out | | ☐ Nursing Home 5 ☐ Residence | 6 Other (Specify) | | | | | | | |
| ΞI | 27. MANNER OF DEATH | 28e. OATE OF INJURY (Month, Day, Year) | 28b. TIME C | | 28d. DESCRIBE NO | V INJURY OC | CURED | | | | | |
| | 1 National 5 Pending | (Morar, Day, Idair) | III | M 1 YES 2 NO | | | | | | | | |
| B | 2 Suitelde | 28e. PLACE OF INJUR | Y — At home, term, stre | et, fectory, office | 281. LOCATION (Stre | et and Numbe | r or Rumi Ar | uta Number | | | | |
| | 8 Could not be 4 Homicide determined | building, etc. (Spe | ecify) | ,, | City or Town, Ste | | CONTROL TO | role realition, | | | | |
| | | | | | | | | | | | | |
| COMPLETED | | CIAN: To the best of my know | wledge, death occurred | nt the time, date end place, and due | to the ceuse(s) and i | nanner ee ata | nted. | | | | | |
| 2 | one) 2 MEOICAL EXAMINE | R: On the beals of examination | on and/or investigation, | in my opinion, death occured at the | time, data and place, | end dua to ti | he ceuse(e) | end menner ee stated. | | | | |
| | 296. SIGNATORE AND TUTLE OF CERTIFIER | | | | - | | | ,, | | | | |
| BE | Nat Da | 11-0 | JI | 29c. LICENSE NUI | | 29d. DAT | E SIGNED | (Month, Dey, Year) | | | | |
| [] | / WAT ! COL | | 14 | 1237 | 36 | | 5/22 | Tip | | | | |
| | 30. NAME AND ADDRESS OF PERSON WAS | O COMPLETED CAUSE OF O | EATH (ITEM 27) (Type, Pr | int) | | - | | 40 | | | | |
| | THE PROPERTY OF PERSON WAY | | ALTER- | _ | | | | | | | | |
| | | | 145 E | CARROLC S | 50 . 3 | 37/20 | SRU | my Ma | | | | |
| | | Coviet | 145E | CARROLCS | 50 . | SVEC | SRU | my na | | | | |
| | 1 JOHN BART. | 32. DEGISTRAR'S SIGN | NATURE OF ROAD | CARROLCS | 50 . 3 | SVEC | SRU | ry Ma | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CER | ITIFIC | AIE O | F DEATH | R | EG. NO. | | | | |
|--|--|---|--|--|----------------|---|-------------------------------|--------------|---------------|---|--|-------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) GREGORY | JAMES | 5 | В | RIGH' | ГМАN | 2. DATE OF C MONTH AUG. | DEATH DAY | | AR | ME OF DEAT | тр м |
| | 4. SOCIAL SECURITY NUMBER | | AGE (In yrs. last bir | | UNDER 1 YEAR | | 7. DATE OF B | URTH | 8.1 | | E (State or Fo | - |
| | 215-58-5983 9e. FACILITY NAME (If not institution, give s | 1 M 2 D F | 43 | YRS. | | | Sept. | 18.1 | 950 I | llin | nois | |
| N. | 12390 JULIAN I | | | | | OR LOCATION OF D | | | 9c. COUNTY | | | |
| CL | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT | , | | OF OUT V | OWN OR LOC | | | | SOME | | | |
| DIRECTOR | | erset | | | | | | | | | INSIDE CITY LIMITS? YES 2 [44 | |
| | 10e. STREET AND NUMBER | erset | | | Circle: | SS Anne | • | T | 10g. CITIZEN | | - | - |
| FUNERAL | 12390 Julian L | ane | | | | 21853 | | | | U.S. | | |
| | 11. MARITAL STATUS 1 Never Merried 2 Merried | 12. WAS DECEDENT EV FORCES? 1 P | YES 2 NO | 0 | If yes, | ECENDENT OF HISPAI specify Cubeo, Maxico | en, Puerlo Rican | pecify Yes (| | 14. RACE — American Indian, Black, White, etc. | | ın, |
| ВУ | 3 Wildowed 4 Divorced | 8-30-71 to | The state of the s | | | | | | | Specify: Vhite | е | |
| TED | 15. DECEDENT'S EDU (Specify only highest grade | completed) | (Give i | 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working) 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | |
| PLE | Elementary/Secondary (0-12) | College (1-4 or 5+) | Guns | Gunsmith, Waterman Firearms/Seafo Construction | | | | | | | | |
| COMPLET | 12 CARPENTER CONSTRUCT: 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) | | | | | | | | | UII | | |
| BE (| James Bright | man | | | | | Louis | | | | | |
| 190. INFORMANT'S NAME (Type/Print) 190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Tow 190. INFORMANT'S NAME (Type/Print) 190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Tow 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Tow | | | | | | | | | | | | |
| | 20e, METHOD OF DISPOSITION | | 20b. PLACE AND | DATEOFD | SPOSITION | | DATE | | ATION — City | | | |
| | 1 Burlet 2 Cremation 3 Ramoval trom Stata Commetery, cramatory or other place Salisbury Crematory 8/20 Salisbury Mar | | | | | | | | | | rvlanc | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | | | AND ADDRESS OF FA | CILITY | | , | , | , | |
| | James d. l | Hinman Funeral Home M00295 Hinman Funeral Home 11673 Somerset Ave Pr Anne Md 2185: The diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate | | | | | | | | | | 3 53 |
| | shock, or heart feilure. IMMEDIATE CAUSE (Finel | List Dnly Dne cause o | on aech line. | | | | | · | | | Approximation interval Be Onset and | etween |
| CERTIFICATION | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Chronic S (S AND FATTY L I USN DUE TO (OR AS A CONSEQUENCE OF): b. Citroyuc D Cuotage Due TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| | PART II. Other significent condition | s contributing to dee | th but not resu | ilting in th | ne underly | ng ceuse given in | Part I. 24e | . WAS AN A | | | AUTOPSY FI | |
| MEDICAL | | | | | | | 16 | YES 2 | | COMP | ABLE PRIOR DE CONTRACTOR DE CO | |
| | | | | | _ | | | | | 1 🗆 | YES 2 P | 10 |
| AN | DID TOBACCO USE CONTI | RIBUTE TO CAUSI | 28. PLACE O | | | | N 🗆 📗 | | | | | |
| PHYSICIAN: | EXAMINER? | HOSPITAL: 1 Inpetient 2 ER/ | | 01 | HER: | me Y X Residence | 6 Other (Spi | ecify) | | | | |
| ВУ РНУ | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28s. DATE OF INJU (Month, Day, Ye | | Bb. TIME DF | 28c. I | NJURY AT WORK? YES 2 ND | | | JURY OCCURE | ED | - | |
| | 2 Accident investigation 3 Suicide 6 Could not be determined | 28s. PLACE OF INJ building, etc. | URY — At home, 'Specify) | farm, stree | l, factory, of | lica | 281. LOCATION | | d Number or R | lural Route N | lumber, | |
| COMPLET | opei | CIAN: To the best of my is | | | | | | | | | | |
| S | 2 X MEDICAL EXAMINE | | ation end/or inve | atigation, in | my opinion | death occured at the | time, data end | place, end | due to the ce | use(e) and i | manner ee si | tated. |
| TO BE | 296. SEPRETURE AND TITLE OF CERTIFIES | Mull | M | 0 | | O.C.M. | | | P AU(| | | 94 |
| | Marysens | | 111 Pe | | | et, Balt | imore | , Ma | ryla | nd 2 | 1201 | |
| | 31. DATÉ FILED (Month, Day, Year) 32, REGISTRAR'S 90 MATURE AUG 2 3 1994 July Standard Control | | | | | | | | | | | |

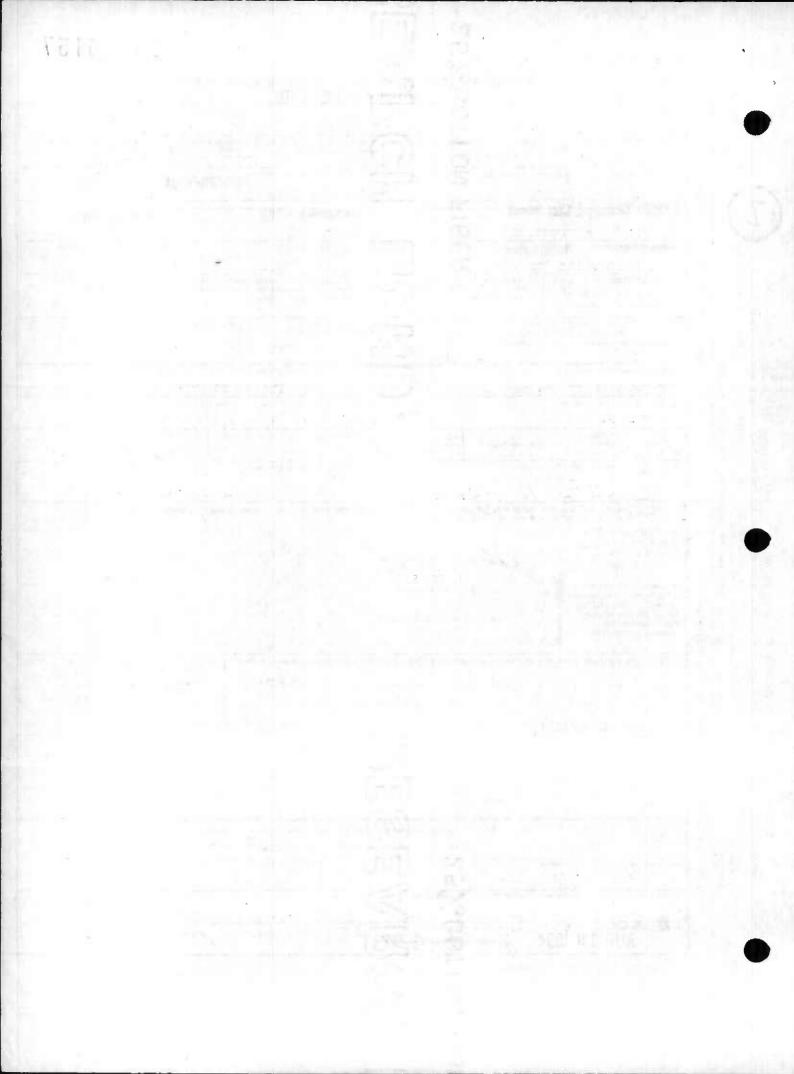
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a completely liked in by the funeral director, page 5 should be detached for use as the burial-transit be fined within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| - | 1. DECEDENT'S NAME (First, Middle, Last) | | | | OTTIE OF | DEATH | _ | EG. NO. | | T | | |
|-------------------------------|--|---|--|----------------|--|--|--|--|---|--|--|--|
| | | | | | | | 2. DATE OF MONTH | DAY | | | | |
| | Lola Taylor 1 | | | | | | 08 | 13 | 1994 | 10:15 a | | |
| | 217-42-5872 | 5. SEX 1 M 2 F | 8. AGE (In yrs. Ia: 84 | YRS. | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF (Morth, Da) 06/28 | ly, Yoar) | Cor | orthpLACE (State or Foreign printy) | | |
| стов | 9a. FACILITY NAME (If not institution, give 1920 Unionville] RESIDENCE OF DECEDENT | 20-11/20-12/2007 | 建 | | | or Location of ke City | DEATH | | Worces | | | |
| DIREC | 10a. STATE 10b. COUNT | » ester | | | TOWN OR LOCA | | | | | 10d. INSIDE CITY LIMITS? | | |
| ERAL D | Maryland Worce | ester | 12 | PC | ocomoke 10 | 1. ZIP CODE | | | 10g. CITIZEN O | 1 TYES 2 XNO | | |
| NER | 1920 Unionville I | | NT EVER IN U.S. AF | Dan CD | 1 40 UMO DE | 2185 | | | | SA | | |
| BY FUN | 1 Never Married 2 Married 3 Wildowed 4 Divorced | FORCES? 1 | YES 2 X | NO | If yes, sp | CENDENT OF HISF pecify Cuban, Maxi 5 2 XNO Spe | can, Puarto Rica | | В | ACE — American Indian, lack, Whita, atc. pecify: White | | |
| LETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refired.) HOMEMAKET and Day Care | | | | | | | | | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | | | | | |
| BE C | Smauel Henry Taylor Lillie Bloxom See INFORMANT'S NAME (Intelligible) See INFORMANT'S NAME (Intelligible) See INFORMANT'S NAME (Intelligible) | | | | | | | | | | | |
| 2 | 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7390 Patrick Rd., Easton, Md. 21601–4822 | | | | | | | | | | | |
| | 20g. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION DATE 20c. LOCATION — City or Town, | | | | | | | | | | | |
| | First Baptist Cemetery 8/15 Pocomoke City, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | | |
| | Scatts | mel | 7 | | | son Fund BOX 64, | | | tv. Md | . 21851 | | |
| CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in daath) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in daath) LAST Onset and Daath Onset and Daath Onset and Daath DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| DICAL CE | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE ALL | | | | | | | | | | | |
| 0 | 1 □ YES X 🖾 NO | | | | | | | | | 24b. WERE AUTOPSY FINDING AWAILABLE PRIOR TO | | |
| ME | | | | | tha underlyin | g cause given | | PERFORM | NED? | | | |
| ME | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | 26. P | g cause given | _ 1 | PERFORM | NED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| ME | EXAMINER? 1 YES 2 NO | HOSPITAL: | ☐ ER/Oulpetlent | 3 DOA | 26. P OTHER: 4 \(Nursing Hore | LACE OF DEATH (| Check only one) | PERFORM YES 2(| MED? | COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| PHYSICIAN: ME | EXAMINER? | HOSPITAL: 1 Inpatient 2 28e. DATE 01 (Month, I | F INJURY Day, Year) | 28b, TIME | 26. P OTHER: 4 Nursing Hor OF 28c. IN RY W H 1 | LACE OF DEATH (me 5 Residence JURY AT ORK? YES 2 \(\square\) NO | Check only one) | PERFORM YES 2(| NED? | AWILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| ED BY PHYSICIAN: ME | EXAMINER? 1 ☐ YES 2 ☑ NO 27. MANNER OF DEATH 1 ☑ Netural 5 ☐ Pending | HOSPITAL: 1 Inpetient 2 28e. DATE 0 (Month, I | F INJURY | 28b, TIME | 26. P OTHER: 4 Nursing Hor OF 28c. IN RY W H 1 | LACE OF DEATH (me 5 Residence JURY AT ORK? YES 2 \(\square\) NO | Check only one) a 6 Other (S 28d. DESCR | PERFORM YES X | JURY OCCURED | AWILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| ETED BY PHYSICIAN: ME | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only) | HOSPITAL: 1 Inpatient 2 28e. DATE 0 (Month, i) 28e. PLACE building | FINJURY Day, Year) OF INJURY — At h., alc. (Specify) | 28b. TIME INJU | 26. POTHER: 4 Nursing Hor OF 28c. IN W 1 | LACE OF DEATH (me 5 Residence JURY AT ORK? YES 2 NO ce a and place, end d | Check only one) a 6 Other (S 28d. DESCR 28l. LOCATH City or 1 | PERFORM VES 2(Decify) BE HOW IN ON (Street ar own, State) | JURY OCCURED Ind Number or Rul Ter se stated. | AWILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO rai Route Number, | | |
| BE COMPLETED BY PHYSICIAN: ME | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMIN | HOSPITAL: 1 Inpatient 2 28e. DATE Of (Month, is) 28e. PLACE building SICIAN: To the best of the basis of | FINJURY Day, Year) OF INJURY — At h. I, atc. (Specify) of my knowledge, d axamination and/or | 28b. TIME INJU | 26. POTHER: 4 Nursing Hor Nursing Hor Nursing Hor Nursing Hor Nursing Hor 1 1 1 1 reel, lactory, office i at the time, det | LACE OF DEATH (me 5 Residence 1 JURY AT ORK? YES 2 NO ce a and place, end death occured at the second se | Check only one) a 6 Other (S 28d. DESCR 281. LOCATH City or 1 | PERFORM YES VES ODECTIVE ODECT | JURY OCCURED In the resisted, due to the cause 29d. DATE SIGN | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO NO PART ROUTE Number, NED (Month, Dey, Yeer) | | |
| E COMPLETED BY PHYSICIAN: ME | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident 8 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON W | HOSPITAL: 1 Inpatient 2 28e. DATE Of (Month, is) 28e. PLACE building SICIAN: To the best of the basis of | FINJURY Day, Year) OF INJURY — At h. h, etc. (Specify) of my knowledge, d axamination and/or | 28b. TIME INJU | 26. POTHER: 4 Nursing Hor Nursing Hor Nursing Hor Nursing Hor Nursing Hor 1 1 1 1 reel, lactory, office i at the time, det | LACE OF DEATH (me 5 Residence 1 JURY AT ORK? YES 2 NO ce a and place, end death occured at the second se | Check only one) a 6 Other (S 28d. DESCR 281. LOCATH City or 1 | PERFORM YES VES ODECTIVE ODECT | JURY OCCURED In the resisted, due to the cause 29d. DATE SIGN | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO NO PARTIE NO P | | |



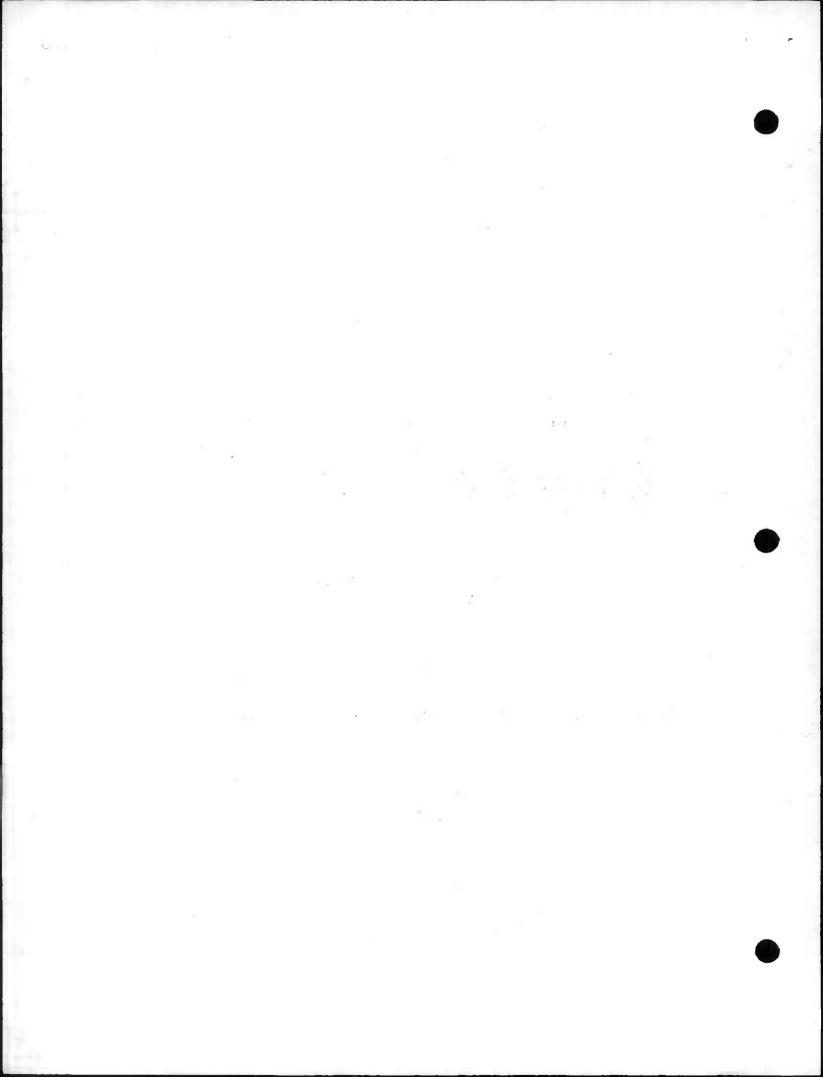
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| rector, | | MUS |
| MELION. After this certificate has been signed by the attending physician and compretely there in by the tuneral director, page 3 should be detached | | m 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once |
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| ATTE | urs after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | 8 ma |
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AUG 03 1994

31. DATE FILED /Morm.

| | FOR 1 - STATE | STATE OF M | MARYLAND / DEP | | | | | | | | | |
|---------------|---|---|---|--|---------------------------|-------------------------|---|------------------|------------------------|--------------------------|------------|--|
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) Rhona Gen | eva | Bisco | IFICATE e | OF | | | AY | YEAR 3 | 1. TIME OF DEA | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | B. AGE (In yrs. last birthd | | | IF UNDER 24 HRS. | August 1, 7. DATE OF BIRTH (Month, Day, Year) | | B. BIRTHPL Country) | 11:20 ACE (State or F | PM | |
| - 8 | 218-38-8315 | 1 🗆 M 2 💢 🗏 | 87 YRS | | | HOURS MIN. | Feb. 19, | ~ | Mar | yland | | |
| OR | 9a. FACILITY NAME (If not institution, give s St. Mary's Nursin | g Center | | | | LOCATION OF DEA TOWN | ATH . | St. | Mary | | | |
| DIRECTOR | 10a. STATE 10b. COUNT | Y | 10c. | CITY, TOWN O | R LOCATIO | ON | | | 1 | 0d. INSIDE CIT | Y | |
| | | t. Mary's | 5 | Piney | Poir | nt | | | _ 1 | LIMITS? | ENO | |
| FUNERAL | 10e. STREET AND NUMBER | | | 10f. ZIP CODE 10g. CITIZEN O | | | | | | | | |
| 핗 | 257 Ball Point R | | T EVER IN U.S. ARMED | 20674 U.S.A. PMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No 14. RACE — AI | | | | | | A. American Indi | llen | |
| B≼ | 1 Never Married 2 Married 3 X Widowed 4 Divorced | | YES 2 NO | If yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 YES 2 NO Specify: Specify: White, atc. | | | | | | White, atc. | 100/1, | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | (Give kind | EDENT'S USUAL OCCUPATION kind of work done during most of working to NOT use retired.) | | | | | | | | | |
| MP | 8th Grade | | Ho | memake | er | | | Home | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) Robert | Edgar | Savre | | | | E (First, Middle, Meiden Catherine | Surname) | Eva | ne | | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) | Lagar | | ING ADDRESS | (Street and | | oute Number, City or Tow | rn, State, Zip C | | .15 | | |
| F | Julie A. Petroff | | | | | | Point, Mar | | | | | |
| | 20s. METHOD OF DISPOSITION 1 [X Burdal 2 Crametlon 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION — City or Town, State St. Georges Island, Meth. 8/4/94 20c. LOCATION — City or Town, State St. Georges Island, Mary land 20c. LOCATION — City or Town, State St. Georges Island, Mary land 20c. LOCATION — City or Town, State St. Georges Island, Mary land | | | | | | | | | | | |
| | Michael | f Xhu | liner | Ma P. | name and ittin O. B | gley-Gar ox 270, | diner Fun Leonardto | eral H wn, Ma | Home, | P.A. | | |
| | 23. PART I Enter the diseases, or shock, or heart failure. | complications that List only one cau | t caused the death. D se on each line. | o not enter | the mod | e of dying, such | as cardiac or resp | iratory arres | st, | Approxim | | |
| | IMMEDIATE CAUSE (Final disease or condition Onset and Death | | | | | | | | | | | |
| | resulting in death) a. Out to (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| N N | Sequentially list conditions, | | | | | | | | | | | |
| ATIC | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury that initiated events | DUE TO | OR AS A CONSEQUENCE | E OF): | | | | | | 1 | | |
| ERI | resulting in death) LAST | d | | | | | | | | | | |
| 0.00 | PART II. Other significant condition | | | ng in thê un | derlying | cause given in P | PERT I. 24s. WAS AN | | | PERE AUTOPSY F | | |
| MEDICAL | | sgan | uc 5 | nain | 24 | me un | 1 Tyes 1 | | 0 | OMPLETION OF | | |
| × | DID 7031.000 USE 4 | (_) | | | _/ | | | (6) | 1 | 77 Z | No | |
| PHYSICIAN: | DID TOBACCO USE C 25. WAS CASE REFERRED TO MEDICAL | ONTRIBUTE | TO CAUSE O | F DEATH | | S NO | x only one) | | | 11/ | | |
| Sic | 1 TYES 2 XNO | HOSPITAL: | ER/Outpatient 3 🗆 DO | OTHER | R: | 5 - Residence 6 | | | | | | |
| ву Рну | 27. MARKER OF DEATY. 1 Natural 5 Peniling 2 Aboldent Investigation | 28e. DATE OF (Month, D | | TIME OF INJURY M | TRC. INJUI WOR | | 28d. DESCRIBE HOW I | MUURY OCCU | (NED | | | |
| | | | | | | | | | | | | |
| COMPLETED | | | my knowledge, death occ | | | | | | | nd manner as i | stated. | |
| BE | 295. SIGNATURE AND TITLE OF CERTIFIE | | whose | M | _ | 29c. LICENSE NUMB | | 294. DATE 1 | | | , | |
| 2 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED THUS | IE OF DEATH (ITEM 27) | Spe, Print) | | U | ou | . 0 | 0 | 17 | | |
| | J. Patrick/Jan | boe, M.D | . 1 | eonar | dtow | n, Maryla | and 2065 | 0 | | | | |

DHMH-16 Rev 1/89



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| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | BALTIMORE, MARYLAND 21215-0020 |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | urs after death. Page 6 may be retained by the hospital or attending physician. |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page filled within 72 hours after death with the State Debt. of Health and Mental Hygiene prior to burial, cremation, or removal. | in by the funeral director, page 5 should be detached for use as the burial-transit permit. Par removal. |
| IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | redical examiner must be notified at once. |

| | D.K.D | | | | | 94 | 26159 | | | |
|--------------|---|---|--|---------------------------------------|----------------------|---|--|--|--|--|
| | 1 - STATE REGISTRAR | | | | | | | | | |
| 100 | 1. DECEDENT'S NAME (First, Middle, Lest) DANIEL A | LAN BUCK | LER | | 3.5 | | | | | |
| TOR | 4. SOCIAL SECURITY NUMBER 217-96-4952 9a. FACILITY NAME (If not institution, give si PRINCE GEORGES | BIRTHPLACE (State or Foreign Country) alvert Co. OF DEATH | | | | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | | | 1111111 | 10d. INSIDE CITY LIMITS? | | | | |
| FUNERAL D | 100. STREET AND NUMBER Star Route Box | | | | | | | | | |
| BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARE FORCES? 1 VES 2 N IF YES, GIVE WAR OR OATES | CENOENT OF HISPAN | in, Puarto Rican, etc.) | n or No— 14. | RACE — American Indian, Black, White, atc. Specify: | | | | |
| COMPLETED | 15. DECEOENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 +) | iive kind of work done during m . Do NOT use retired.) | ost of working | 16b. KIND OF BU | SINESS/INDUST | RY | | | |
| BE | 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surmame) Florence Gertrude Walker | | | | | | | | | |
| TO | Joseph I. Buck 20- METHOD OF DISPOSITION 1 Department 2 Cramation 3 Remo | ler. Sr. S | tar Route | Box 246 | Maddox. | Maryla | and 20621 | | | |
| | Edward N. Br | insfield, Jr. M | 22. NAME A Brit 100052 P.O. | no address of fa isfield Box 27 | Funeral 9,Leonar | Home dtown, | ,Maryland | | | |
| | 23. PART I. Enter the diseases, or cashock, or heert failure. Immediate CAUSE (Finel disease or condition resulting in death) | e. Multiple OUE TO (OR AS A CONSEC |). | ode of dying, suc | h ss cardiac or reep | ratory arreet, | Approximate interval Between Onset and Death | | | |
| ERTIFICATION | Sequentially list conditions, if any, leading to immediate ceuse. Entar UNDERLYING CAUSE (Disease or Injury | | | | | | | | | |
| CERTIF | thet initiated evente resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| : MEDICAL | PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? 17 YES 2 NO 24b. WERE ANALLY COMPTON OF DE | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | CE OF DEATH (Check only one) |) | | | | | | |
| ВУ РНУ | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 26a. DATE OF INJURY (Month, Day, Year) 8-6-94 | 28b. TIME OF 18c. IN. WI | JURY AT ORK? YES 2 NO | motor uch | ch acc | ident | | | |
| ETED. | 3 Suicide 6 Could not be determined | Street | | | Charles (| R+5 am | ural Route Number, LR + 488 | | | |
| COMPLETED | one) 2 X MEOICAL EXAMINE | R: On the basis of axamination and/or is | BUCKLER AUG. 06 94 0 Belling of the following of the part of | use(a) and manner as stated. | | | | | | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | an a | | 29c. LICENSE NUM | WBER | 29d. DATE SIG | INED (Month, Day, Year) | | | |

296. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER O.C.M.E

29d. DATE SIGNED (Month, Day, Year) AUG. 07,1994

30. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF CEATH (ITEM 27) (Type, Print) Street, Baltimore, Maryland 21201

31. DATE ALEG (Jonin Day 1994

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92. REGISTRAR'S SIGNATURE

DHMH-18 Ray 1/89

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John Fenwick,
31. DATE FILED MONTH DOWN 9 19

M.D.

1994

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| | FOR | CTATE OF I | MADVIAND / | DEDAG | YTR4EN | T OF U | PAITU | AND A | MENTAL HYGIEN | | | | |
| | 1 - STATE REGISTRAR | SIMIE UT | | | | | DEAT | | MENIAL HYGIEN REG. NO | _ | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | - | | | | 2. DATE OF DEATH | | | 3. TIME OF | DEATH |
| - 1 | Mary Amelia Bu | utterfi | eld | | | | | | | , 19 | 994 | 5:45 | A M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. lest | it birthday) | | R 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF BIRTN (Month, Day, Year) | | | HPLACE (State | or Foreign |
| | 213-44-6022 | 1 M 2 XF | 95 | YRS. | MONTHS | DAYS | HOURS | MIN. | July 5,1 | 899 | | | ginia |
| - | 9a. FACILITY NAME (If not institution, give s | | | | 9b. CIT | Y, TOWN O | R LOCATIO | ON OF DE | ATH | 9c. COU | NTY OF D | DEATH | |
| 10 | 89A Maycroft Road | | | | Ave | enue | : | | | St | . Ma | ary's | |
| DIRECTOR | 10a. STATE 10b. COUNTY | | | | Y, TOWN | OR LOCAT | ION | | | 10d. INSIDE CITY | | | |
| | Maryland St. | Mary's | | Av | enue | e | | | | LIMITS? 1 YES 2 NO | | | |
| IA! | 10e. STREET AND NUMBER | | | | | _ | . ZIP CODE | | | 10g. CIT | IZEN OF | WHAT COUNT | RY7 |
| 삘 | 89A Maycroft H | | | | | 2 | 0609 | 9 | | Uni | ted | Stat | 05 |
| FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDEN FORCES? 1 | TEVER IN U.S. ARI | MED | 13. | WAS DECI | ENDENT OF | F HISPANI | IIC ORIGIN? (Specify Yes | | 14. RAC | E — American | |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE W | | | | 1 TYES | 2 X NO | Specify | n, Puarto Rican, etc.) | | Whi | | |
| | 15. DECEDENT'S EDUC | CATION | 16a. DE | CEDENT'S | USUAL (| OCCUPATIO |)N | | 16b. KIND OF BU | SINESS/INC | | 1 6 6 | |
| ETED | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 | (Gi | ive kind of a | work done se retired.) | during mos | st of working | g | 1000 15000 01 -2 | OHTE CONT. | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | |
| [필 | 7 | Sanaga (| | mema | akei | r | | | | | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTN | ER'S NAM | ME (First, Middle, Maiden | Surname) | | | |
| BE (| Albert Martin | | | | | | | | et Combs | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | | | Route Number, City or Tow | | | | |
| | Roger Butterfi | | P | .0. | Box | x 31 | 3, I | <u>eon</u> | ardtown. | Ma | ryla | and 2 | 0650 |
| | 20 METNOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Rem 4 Donation 5 965 (Specify) | oval from State | 20b. PLACE A | enstony or o | ther niere | 1 | | | | CATION — | | | |
| 1 | 21. SIGNATURE STANSFILL SERVICE LIE | OSEE / | AMS | Alnı | 22. | . NAME AN | ID ADDRES | S OF FAC | CILITY | | | aryla | nd |
| | S/11/0/11 F | an " | / | | E | Brin | sfie | eld | Funeral | _ | | | |
| \vdash | Edward N. B | | | | F | 2.0. | Вох | 27 | 9,Leonar | dtor | vn, M | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fallura. List only one cause on each line. Approximate interval Between | | | | | | | | | | | | |
| | iMMEDIATE CAUSE (Final disease or condition) // fr fr fr fr fr fr fr fr fr fr fr fr fr | | | | | | | | | | | | |
| | resulting in daeth) | a. DUE TO | OR AS A CONSE | OUENCE O | Cel | 1 dee | c a | me | 1+- | | | | |
| _ | Due to (or as a consequence of): Sequentially list conditions b. Cert by Usular are a day t | | | | | | | | | | | | |
| ERTIFICATION | Sequentially list conditions, if any, leading to immediate b. Cert by Unular are a due to the point of the property of the pr | | | | | | | | | | | | |
| CA | csuse. Enter UNDERLYING CAUSE (Disease or injury | С. | | | | | | | | | | | |
| E | that initiated events resulting in death) LAST | DUE TO | (OR AS A CONSEC | DUENCE OF | F): | | | | | | | | |
| | resoning in deading CAST | d | | | | | | | | | | | |
| AL C | PART ii. Other significant condition | s contributing to | death but not r | esuiting | in the u | ndariying | cause g | iven in f | | | 24t | b. WERE AUTOP | |
| MEDICAL | Cardionyo | La ten | 4 | | | | | | PERFOR | _ | - | COMPLETION OF DEATH? | |
| ME | | 4 < | 7. | | | | | | | 69 | | 1 TYES 2 | ≀ □ NO |
| ä | DID TOBACCO USE C | ONTRIBUTE | TO CAUS | E OF | DEAT | TH YE | ES 🗆 | NO | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHE | | ACE OF DE | ATN (Che | ock only one) | | | | |
| YSI | 1 TYES 2 THO | 1 - Inpetient 2 | ER/Outpatient 3 | - | _ | | o 5 M Rec | eldence (| 8 Other (Specify) | | | | |
| | 27. MANNER OF DEATN 1 Natural 5 Pending | 28a. DATE OF (Month, D | | 28b. TIM INJ | IE OF JURY | 28c, INJU WOI | RK? | | 28d. DEŞCRIBE NOW I | NJURY OC | CURED | | |
| B A | 2 Accident Investigation | 200 BLACE C | 26. 101 H 1024 | | M | | /E\$ 2 | NO | | | | | |
| 8 | 3 Suicide 6 Could not be 4 Nomicide determined | building, | OF INJURY — At hor , atc. (Specify) | me, rarm, s | Areet, fac | nory, office | 1 | | 281. LOCATION (Street : City or Town, State) | | r or Runal I | Route Number, | |
| | 29a. CERTIFIER | | | | | | | | | | | | |
| COMPL | (Check only one) 2 MEDICAL EXAMINE | | | | | | | | to the cause(s) and mai | | | Profes de l'Arresto | |
| 8 | 29b. SIGNATURE AND TITLE OF CERTIFIER | | xamination and/or is | nvestigatio | ın, ın my c | opinion, de | | | | | | | |
| H | 290. SIGNATURE AND TITLE OF CERTIFIES | | | | | | 29c. LICEI | | IBER | | | D (Month, Day, | Ybar) |
| 2 | 30. NAME AND ADDRESS OF PERSON WN | O COMPLETED CAU | SE OF DEATH (ITEL | M 27) /5 | Drint) | | D01 | 380 | | | 8-8 | .94 | |

D. Medical Arts Bldg., Leonardtown,

Maryland

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the first death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remonal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

FOR 1 STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CE | RTIFIC | ATE OI | DEATH | REG. NO |). | | |
|------------------|---|--|------------------------------|--|--------------|---|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) JAMES |] | BRAGG | | | 2. DATE OF DEATH MONTH DAY YEAR AUGUST 11, 1994 12:05 AM | | | | |
| | | 5. SEX 1 🔀 M 2 🗌 F | 6. AGE (In yrs. less | | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Morth, Day, Year) Jun 13, | | Country) est Virginia | |
| OR | 90. FACILITY NAME (If not institution, give street PHYSICIANS MEMORI | | TAL | 96. CITY, TOWN OR LOCATION OF DEATH LA PLATA | | | | 9c. COUNTY OF DEATH CHARLES | | |
| 티 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | | Man CITY TO | WALOR LOC | ATION | | | Los mone en | |
| DIR | Maryland Char | les | | toc. CITY, TOWN OR LOCATION Hughesville | | | | 10d. INSIDE CITY LIMITS? 1 TYES 2 M NO | | |
| FUNERAL DIRECTOR | 100. STREET AND NUMBER 15830 Scout Camp R | oad | | | 1 | 01. ZIP CODE 20637 | | | OF WHAT COUNTRY? | |
| B | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA | YES 2 X N | MED IO | If yes, s | CENDENT OF HISPAN pecify Cuban, Maxica S 2 NO Specify | | | RACE — American Indian, Black, White, atc. Specify: White | |
| 8 | 15. DECEDENT'S EDUCA (Specify only highest grade co | TION ompleted) | 18a. DE | CEDENT'S USO we kind of work Do NOT use re | JAL OCCUPAT | TION nost of working | 16b. KIND OF BL | ISINESS/INDUST | RY | |
| COMPLET | Elementary/Secondary (0-12) 11th Grade | College (1-4 or 5+) | | Do NOT use re Iron W | | | Unio | on | | |
| ő | 17. FATHER'S NAME (First, Middle, Last) | | | | | 16. MOTHER'S NA | ME (First, Middle, Maider | Sumame) | | |
| BE | Clark J. 190. INFORMANT'S NAME (Type/Print) | ames | | agg | DDF00 (Du. | Mary | Dove | | ylor | |
| 2 | Ruth E. Bragg | | | | | | Hughesvi | | | |
| | 20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Ramov | rel from State | 20b. PLACE A | NO DATE OF D | ISPOSITION (| Varne of | DATE 20c. LC | OCATION City | or Town, State | |
| | 4 Donation 5 Other (Specify) | | Charl | es Men | orial | Gardens | 8/13/94 Le | eonardt | own, Maryland | |
| | Muchael C | NSEE C | 21 -6 | 10- | | | rdiner Fur Leonardto | | | |
| | 23. PART (Enter the diseases, or co shock, or heart fellure. Li | inplications that | caused the de | eth. Do not | | | | | Approximate | |
| | iMMEDIATE CAUSE (Final disease or condition | et brily one caue | dia R. | .0 | 2250 | 1 6.400 | | | Onset and Death | |
| | resulting in death) s. | DUE TO (| OR AS A CONSEC | DUENCE OF): | 1 | 9 arrec | 0/ | | | |
| NO | Sequantielly list conditions, | DUE TO (| DAT LY OR AS A CONSEC | | hal | gracio | 4- | | | |
| ICAT | if sny, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | (0) | celvol | asa | lav | Diflax | 2 | | | |
| CERTIFICATION | thet initiated evente resulting in death) LAST | DUE TO (| OR AS A CONSEC | DUENCE OF): | | | | | | |
| | PART II. Other significant conditions | contributing to | death but not re | esulting in t | he undarivi | ng cause given in | Pert i. 24a. WAS AI | ALITOPSY | 24b. WERE AUTOPSY FINDINGS | |
| DICAL | Hypesternin Hea | , Demertia. | | | PERFO | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | |
| : ME | DID TOBACCO USE C | ONTRIBUTE | TO CAU | SE OF I | DEATH | YES IT NO | <u> </u> | | 1 TES 2 NO | |
| IAN | 25. WAS CASE REFERRED TO MEDICAL | | 10 0/10 | 0 | | PLACE OF DEATH (Ch | | | | |
| SIC | | HOSPITAL: | ER/Outpatient 3 | | THER: | me 5 🗆 Rasidenca | | | | |
| Y PHYSICIAN: | 27. MANNER OF DEATH 1 Natural 5 Pending Investigation | 28a. DATE OF I (Month, Da | | 28b. TIME O | F 28c. II | JURY AT /ORK? YES 2 NO | 28d. DESCRIBE HOW | INJURY OCCURE | ED | |
| TED BY | 2 Accident Investigation 3 Suicide 8 Could not be determined | 28a. PLACE OF building, a | INJURY — At horte. (Specify) | home, farm, street, factory, office 28f. LOC | | | | LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |
| Z.E | 29a. CERTIFIER 1 CERTIFYING PHYSICI. | AN: To the best of r | my knowledge, de | eth occurred a | the time, de | te and place, and due | to the cause(s) and mi | oner se stated | | |
| COMPLET | | | | | | | | | use(s) and menner as stated. | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | t a | tlendin | g Phy | figan | 29c. LICENSE NUN D=12587 | | 29d. DATE SIG | GNED (Month, Day, Year) 0-94 | |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO GIRIJA S. RATH M.D. | COMPLETED CAUS | E OF DEATH (ITER | 1 27) (Type, Pri | rt) | | WALDORF | MD 206 | 502 | |
| | 31. DATE FILED (Month, Day, Year) | | I'S SIGNATURE | | - OLIM | OLIVILIK | MALDOKI | 11D. ZUC | JU 2 | |
| | AUG 1 2 1994 | Jahra alke | SARAI TROUBUR | APAI. | | | | | | |

inj

- 33

| THE PROPERTY OF THE PARTY OF TH | ours after death. Page 6 may be retained by the host | of in by the funeral director, page 5 should be detached | medical examiner must be notified at once. |
|--|--|---|---|
| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to the state of the companies of companies of companies of companies of companies. | be lifed within 12 hours are used with the state beet, or regular and mental higher provide orders, creminated, or letter 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
|-----|---|----------|
| RAR | CERTIFICATE OF DEATH | REG. NO. |

| | 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | |
|--|---|---|------------------------|--------------------|--|---|------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | |
| | Clarence Be | enjamin | Bris | scoe, S | r. | August 22 | | 11:46 A M | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (| In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BIRT | HPLACE (State or Foreign | | |
| | 217-32-4740 9e. FACILITY NAME (If not institution, give stre | 1 M 2 □ F 58 | 3 YRS. | ONTHS DAYS | HOURS MIN. | Jan. 6, 1 | 936 Ma | ryland | | |
| OR | 2-B Lexwood Drive | or one numbery | | | on Park | AIH | St. Ma | | | |
| 띮 | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | 10c. CITY | TOWN OR LOCAT | TION | | | 10d, INSIDE CITY | | |
| DIRECTOR | Maryland St. | | xington Park | | | LIMITS? | | | | |
| FUNERAL | 10e. STREET AND NUMBER | | | 101 | | | | WHAT COUNTRY? | | |
| W | 2-B Lexwood Drive | | | | 20653 | | | Α. | | |
| 5 | 11. MARITAL STATUS 1 Never Married 2 Merried | 12. WAS DECEDENT EVER IN FORCES? 1 YES | 2 X NO | | | IIC ORIGIN? (Specify Yearn, Puerto Rican, etc.) | or No- 14. RAC Blac | E — American Indian, ck, White, etc. | | |
| B | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DA | ATES | 1 TYES | 2 NO Specify | r. | Spec | Black | | |
| 유 | 15. DECEDENT'S EDUCA | ATION | 16e. DECEDENT'S U | SUAL OCCUPATION | ON . | 16b. KIND OF BU | I SINESS/INDUSTRY | DIACK | | |
| | (Specify only highest grade of Elementary/Secondary (0-12) | College (1-4 or 5+) | | rk done during mo | | | | | | |
| 립 | 8th Grade | consign (1-4 or 5 v) | Pressman | n | Newspaper | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Melden | Surname) | | | |
| BE | George William | Briscoe | | | Katie | Ann | Gross | | | |
| 2 | 19e. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or Tow | | | | |
| | Teresa Hopson | | 501 Doi | naldson | Dr., Le | xington Pa | rk, Mary | land 20653 | | |
| | 20a, METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remove | zel from State 20b. | PLACE AND DATE OF | | | DATE 20c. LO | CATION — City or T | own, State | | |
| | 4 Donation 5 Other (Specify) | Pa | ark Hall ' | | | | Park Ha | ll, Maryland | | |
| | SIGNAL OF FUNERAL SERVICE LICE | 27 (/a 1) | | Matti | of address of fair | rdiner Fun | eral Hom | e, P.A. | | |
| | 11 ichael | Lardy | ner | P.O. | Box 270, | Leonardto | wn, Mary | land 20650 | | |
| | 23. PART I. Enter the diseases, or co | mplications that caused | the death. Do no | t enter the mo | de of dying, auci | h aa cardlec or reep | retory arrest, | Approximata | | |
| | IMMEDIATE CAUSE (Final | 0 1 \ | | 0.5 | | | | Onset and Death | | |
| | disease or condition reaulting in deeth) | -HKDIO | OMYO | PAI. | HY | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): A | | | | | | | | | |
| S | Sequentially list conditions, CORENARY ARTERY DISEASE. | | | | | | | | | |
| E | DUE TO (OR AS A CONSCOUÊNCE OF): (If any, leading to immediate cause, Enter UNDERLYING | | | | | | | | | |
| 음 | CAUSE (Disease or injury | | | | | | | | | |
| CERTIFICATION | thet initiated evente resulting in deeth) LAST | | | | | | | | | |
| | DART II On and all and a state of | PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | |
| AL | CLV & | contributing to deeth be | ut not resulting in | the underlyin | | Part I. 24s. WAS AN PERFOR | | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | |
| ă | - Of Of Cert | -Drova | sand | 1 | cc/d | YES 2 | ₩ NO | OF DEATH? | | |
| M | DID TODA COO HEE CO | | | | | _ 1 | | 1 TYES 2 NO | | |
| PHYSICIAN: MEDIC | DID TOBACCO USE CO | NIRIBUTE TO C | CAUSE OF D | | | | | | | |
| S | EXAMINER? | HOSPITAL: | | OTHER: | ACE OF DEATH (Ch | | | | | |
| 4 | 1 N YES 2 NO 27. MANNER OF DEATH | 1 Inpatient 2 ER/Outp 26e, DATE OF INJURY | 28b. TIME | | | 6 Other (Specify) | | | | |
| | 1 X Natural 5 Pending | (Month, Day, Year) | INJUI | RY WC | RK? | 26d. DESCRIBE HOW I | NJURY OCCURED | | | |
| В | 2 Accident Investigation 3 Suicide Could get be | 28e. PLACE OF INJURY | - At home, ferm, str | | YES 2 NO office 28f. LOCATION (Street and Number or Rural Route Number, | | | | | |
| COMPLETED | 4 Homicide B Could not be determined | building, etc. (Spec | etty) | eer, rectory, orne | | City or Town, State) | and reamber or nurar | nodie Number, | | |
| ,E | 290. CERTIFIER 1 X CERTIFYING PHYSIC | IAN: To the best of my knowle | ledge, death occurred | at the time date | and place, and due | to the cause(s) and may | nor or stated | | | |
| ME | (Check only one) 2 MEDICAL EXAMINER | On the beele of examinetion | end/or investigation, | In my opinion, d | eath occured at the | Ilme, date end place, en | d due to the couse | e) end manner ee stated. | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | , | | 29c. LICENSE NUM | | | D (Month, Day, Year) | | |
| BE (| | UQ12 | . 12 | | D23634 | LIFE LIFE | DQ/2 | 2194 | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | | | | | oonard+or- | Marri - | and 20650 | | |
| | Adinath A. Patil, | | | arcar C | enter, L | eonardtowr | , ratyle | IIIQ 20030 | | |
| 31. DATE FILED (MONTH, Day, Year) AUG 25 1994 AUG 25 1994 AUG 25 1994 AUG 25 1994 | | | | | | | | | | |

**

THE STATE OF THE S

| | 1 - STATE REGISTRAR | | CEF | RTIF | ICATE | OF | DEAT | TH | "EN IAL | REG. NO. | | | |
|------------------|---|------------------------------|--|-----------|------------------------------|------------|----------|-----------------|----------------|-----------------------------------|------------|-------------------|---|
| | t. DECEDENT'S NAME (First, Middle, Last) | | | _ | | | * | | | OF DEATH | W 1 00 / | YEAR | 3. TIME OF DEATH |
| | Charles | | | | uldin | | | | Jüly | 7 28" | 1994 | | 12:45 a M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last bi | | IF UNDER 1 | DAYS | IF UNDER | 24 HRS. MIN. | 7. DATE (| Dey, Year) | | 8. BIRTHI | PLACE (State or Foreign |
| | 220-40-5889 9a. FACILITY NAME (If not institution, give s | | 47 | YRS. | | | | | | y 2,19 | | | cyland |
| œ | | | | | 9b. CITY, | | | ON OF DE | ATH | | | TY OF DE | |
| 5 | Easton Memorial H | ospital | | | _ Ea | asto | <u>n</u> | | | | | Talbo | ot |
| REC | 10a. STATE 10b. COUNTY | | 1 | IOc. CIT | Y, TOWN OF | | | | | | | | 10d. INSIDE CITY LIMITS? |
| 0 | | en Anne | | | Gras | _ | ille | | | | | | 1 - YES 2 -XNO |
| FUNERAL DIRECTOR | 210 Wilson Road | | | | | 101. | ZIP COD | 1 2163 | 8 | | | ZEN OF W USA | HAT COUNTRY? |
| F | t1. MARITAL STATUS 1 Never Married 2 X Married | | EVER IN U.S. ARME | D | 13. W | AS DECI | ENDENT C | F HISPAN | IIC ORIGIN: | ? (Specify Yes | or No- | 14. RACE Black | - American Indian, White, atc. |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE W | 66-Aug.1 | 072 | | | | Specify | | ioari, aro., | | Specif | Black |
| | 15. DECEDENT'S EDU | CATION | | | USUAL OC | CUPATIO | N | | 16b. | KIND OF BUS | SINESS/IND | USTRY | |
| | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give | kind of t | work done do se retired.) | | | g | | | | | |
| MPL | 12th | | | Lab | orer | | | | (| Dyster | & C. | lam I | Factory |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTI | | | liddle, Malden | | | |
| BE | Norman Bouldin | | | | | | | | | M. Wa | | | |
| 9 | Carrie thomas | | | | | | | | | or, City or Yow ille, | | , | |
| | 20a, METHOD OF DISPOSITION | | 20b. PLACEANI | DATE | OF DISPOSIT | TION (Nat | me of | | DATE | | CATION — | | vo State |
| | 1)∑Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify) | oval from Stata | cemetery, crema | tory or o | ther place) | h C | eme t | erv | i bair | | | | Maryland |
| | 21. SIGNATURE OF FUNERAL MANUEL LIE | STREET | - | | 22. N | IAME AN | O ADDRE | SS OF FAC | | | | | |
| | 19 | | | | Ber | mle | Del | tn F awar | unera e 190 | al Hom 903 | ie, P | .U. t | 91 |
| | 23. PART I. Enter the diseases, pr | complications thet | caused the death | h. Do r | not enter t | the mod | de of dy | ing, such | h as cerd | ac or respi | ratory err | eat, | Approximate |
| | ahock, or heert feliure. IMMEDIATE CAUSE (Final disease or condition | List Drily Dria caus | se on aach line. | , | | | | | | | | | Interval Between Onset and Death |
| | resulting in death) | DUE TO | OR AS A CONSEQUE | ENCE-O | F): | | | 10 | | 20 () | | | cgus |
| z | | Male | snant | Ca | rai | will | 67 | The | AM | Al bo | wel | | 1044 |
| 일 | Sequentially list conditions, if any, leeding to immediate | DUE TO | AS A CONSEQUE | ENCE O | F): | | | | | | | | |
| 2 | CAUSE (Disease or Injury | C. DUE TO | OR AS A CONSEQUE | NOE O | | | | | | | | | |
| CERTIFICATION | thet initieted events resulting in death) LAST | | ON AS A CONSEQUE | INCE O | r): | | | | | | | | |
| | | 1. | | | | | | | | | | | |
| DICAL | PART II. Other aignificant condition | s contributing to | death but not read | ulting | | | | liven in I | | 24e. WAS AN PERFOR | | | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO |
| ğ | rulonoran | - Ol No | struck | 7 | Cu | real | - | 117 > | _ | 1 _ YES 2 | 700 | | COMPLETION DF CAUSE OF DEATH? |
| Σ | simole or | mer ou | of were | n. | tu | real | h | 95 | <u> </u> | | | | t 🗌 YES 2 🗎 NO |
| PHYSICIAN: ME | 25. WAS CASE REFERRED TO MEDICAL | | | | | 28. PL | ACE OF D | EATH (Che | eck only one | 0) | | | |
| SIC | EXAMINER? | HOSPITAL: | ER/Outpatient 3 🗆 | DOA | OTHER | : | | | 8 🗆 Other | | | | |
| | 27. MANNER OF DEATH | 28a. DATE OF I | | ab. TIM | | 28c. INJU | JRY AT | | | CRIBE HOW I | NJURY OCC | URED | |
| BY | 1 V Natural 5 Pending 2 Accident Investigation | (,,,,,,,,, | y. 1547) | | M | | ES 2 | NO | | | | | |
| COMPLETED | 3 Suicide a Could not be 4 Homicide detarmined | 28s. PLACE OF building, a | INJURY — At home atc. (Specify) | , farm, | streel, facto | ry, office | | | | TION (Street I or Town, State) | and Number | or Rural R | oute Number, |
| | 29a. CERTIFIER 1 CERTIFYING PHYSI | CIAN: To the best of r | my knowledge death | | -4 -4 45 - 41- | | | | | 27.10.23 | estestaty | | |
| DMF | (Check only one) 2 MEDICAL EXAMINE | | | | | | | | | | | | and manner ea stated. |
| | 296. SIGNATURE AND TITLE OF CERTIFIER | | //\ | 1 | | | | NSE NUM | | | | | (Month, Day Year) |
| O BE | Welliam | HUDDO | 14/1 | 11 |) | | I | 00 5 | 371: | 5 | > r | 35/1 | 194 |
| 10 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUS | E DE DE ATHYLTEM 2 | 7) (Type | Print) | F | AC | TON | / / | nd | 216 | 01 | |
| 9+ | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAF | A | | 200 | | | | , . | | | / | |
| | r #### 5 U/I | CHINE. | of the Atlanta - (Atlanta de | MAL. | | | | | | | | |

| | FOR |
|---|-----------|
| 1 | STATE |
| | REGISTRAR |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCIENE

| | 1 - STATE REGISTRAR | OINIE OI WI | CE | | | | DEATH | MENT | REG. NO. | | | |
|----------------------|--|--|--|-----------------------|----------------|----------------|--|------------------------------|--|----------|------------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | ELMI | | | BRA | - | | 2. DAT | E OF DEATH | | YEAR 94 | 3. TIME OF DEATH A |
| 3 | 4. SOCIAL SECURITY NUMBER 213-24-0339 | 5. SEX 1 1 M 2 F | 8. AGE (In yrs. lest | birthday) YRS. | IF UNDER | 1 YEAR DAYS | IF UNDER 24 HRS. HOURS MIN. | /A.A. | E OF BIRTH rith, Day, Year) | 927 | Countr | PLACE (State or Foreign |
| OR | 9a. FACILITY NAME (If not institution, give s PENINSULA REGION. | L CENTER | { | | | BURY | | 9c. COUNTY OF GEATH WICOMICO | | | EATH | |
| DIRECTOR | RESIDENCE OF DECEDENT 10e. STATE MARYLAND DORC | Y HESTER | | | Y, TOWN C | | ION | | | | | 10d. INSIDE CITY LIMITS? |
| | 10e, STREET AND NUMBER | HESTER - | | KIL | ופשענ | | | | | | | 1 YES 2 XNO |
| FUNERAL | 4800 RHODESDALE | ROAD | | | | 101 | 21659 | | | | USA | HAT COUNTRY? |
| B | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT FORCES? 1 (2) IF YES, GIVE WAI 1945-1947 | EVER IN U.S. ARM VES 2 NO R OR DATES & 1951 | 195 | | f yes, sp | ENDENT OF HISPAP ecity Cuban, Maxica 2 XNO Specify | n, Puerte | aiN? (Specify Yea o Rican, etc.) | or No- | 14. RACE Black Specifi | — American Indian, White, atc. |
| COMPLETED | 15. DECEOENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5+) | (Giv | e kind of Do NOT u | se retired.) | during mo | N st of working | | 5b. KIND OF BUS | | | |
| M P | 11 | | DI | (SPA | ГСНЕ | · | _ | | TRUCKIN | | MPANY | 7 |
| BE CO | 17. FATHER'S NAME (First, Middle, Lest) ELMER B. BRAMBLE | | | | | | 18. MOTHER'S NA MILDR | | RACHEL | , | EY | |
| 2 | 190. INFORMANT'S NAME (Type/Print) SANDRA B. THOMAS | | | | | | nd Number or Rural I | | | | | 21620 |
| | 20e. METHOD OF DISPOSITION 1 X Buriel 2 Cremation 3 Rem 4 Donation 5 9ther (Specify) | ioval from State | 20b. PLACE AI | | | | me of | 1 | | | O, MI | , |
| | 21. SIGNATURE OF TUNERAL SERVICE LI | CHSED . | 111 | | 22. | NAME AN | O ADDRESS OF FA | CILITY | | | | |
| | Scruel | 9 | lly | | 10 |)6 M | | ET, | EAST N | EW M | ARKE | 207 T, MD 21631 |
| | 23 PART L'Entar tha diseases, or ahock, or heart fallure. IMMEDIATE CAUSE (Final disease or condition resulting in daeth) | a. CAR | on each line. | | not enter | | | h aa ca | rdiac or respi | ratory a | rrest, | Approximate Interval Between Onset and Death |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | b | OR AS A CONSECU | | , | | | | | | | |
| ERTIF | that initiated events resulting in death) LAST | DUE TO (C | OR AS A CONSECU | UENCE O | F): | | | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other eignificant condition | s contributing to d | aath but not re | sulting | In the un | darlying | j causa given in | Part I. | 24s. WAS AN PERFOR | MED? | 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| AN | 25. WAS CASE REFERRED TO MEDICAL | 1 | | | | 20 Dt | ACE OF OEATH (Ch | | | | | |
| SICI | EXAMINER? 1 YES 2 X NO | HOSPITAL: | FB/Outnetlant 3 | DOA | OTHER | 1 : | | | | | | |
| PHY | 27. MANNER OF DEATH | 28e. DATE OF III | JURY | 28b. TIM | E OF | 28c. INJ | | | ESCRIBE HOW II | NJURY O | CCUREO | |
| B | t & Natural 5 Pending 2 Accident Investigation | 2 PACKONIII | | | | | | | | | | |
| | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF building, at | INJURY — At hon ic. (Specify) | ne, lerm, | street, fact | ory, office | ' | 281. LC | CATION (Street a ty or Town, State) | nd Numbe | er or Aural A | oute Number, |
| COMPLETED | 29a. CERTIFIER (Check only 1 CERTIFYING PHYS | | | | | | | | | | | |
| | 290. SKINATURE AND TITLE OF CURTIFIE | | THE STATE OF | rvangan | ni, iii iiiy o | pinion, u | | | ns and piece, an | | | |
| TO BE | Wyh | e 1 | us | | | | D2C | MBER CHE | | 29d. DA | TE SIGNED | (Month, Day, Year) |
| | 30. NAME AND ADDRESS OF PERSON WI | HO S | OF OEATH (ITEM | 27) (Type | | 551 | RIVERSI | DE | DRIVE, | SALI | SBUR | Y,MD 21801 |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR | 'S SIGNATURE | | | | | | | | | |

12

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Jours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

DHMH-16 Rev 1/89

| | | FOR |
|---|---|-----------|
| 1 | _ | STATE |
| | | REGISTRAR |

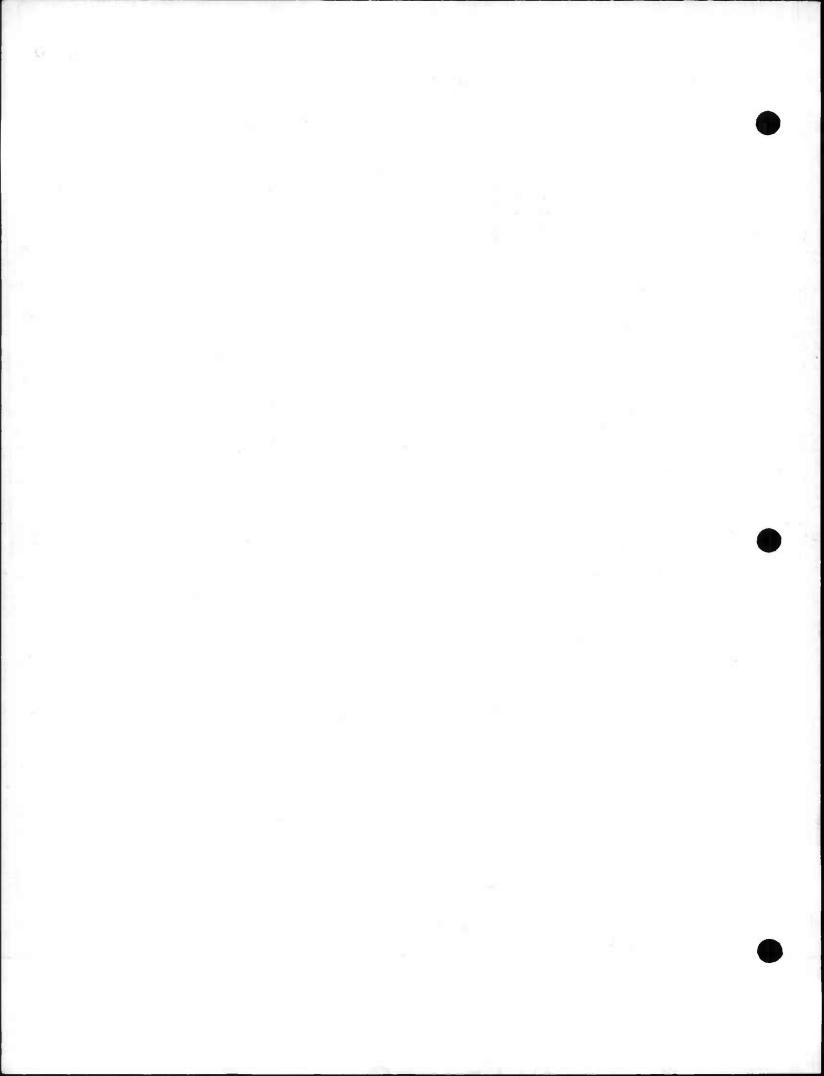
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | CERT | IFICA | TE OF | DEAT | Ή | RE | G. NO. | | | |
|---------------|--|---|-------------------------------|-----------------------|--------------|------------|-----------------------------------|-------------|-----------|--------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF D | | | | 3. TIME OF DEATH |
| 1 | JAMES CLEVELAND | BENTZ | | | | | Pingu | 1 C+ | | YEAR | 2356 PM |
| - 6 | 4. SOCIAL SECURITY NUMBER 5. SEX | 6. AGE (In yrs. last birtho | day) IF UN | DER 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF B | RTH | 20 | 6. BIRTH | IPLACE (State or Foreign |
| | 219-28-2373 1 XM 2 □ F | 66 YR | IS. MONT | B DAYS | HOURS | MIN. | (Month, Day, FEBRUAL | | 10 | Countr 28 | MARYLAND |
| | 9a. FACILITY NAME (If not institution, give street and number) | | 9b. C | ITY, TOWN (| OR LOCATIO | | | <u> </u> | | INTY OF D | |
| TOR | 98. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON RESIDENCE OF DECEMENT | | | | | | | | | | |
| DIRECTOR | 10e. STATE 10b. COUNTY MARYLAND WASHINGTO | | | N OR LOCAT | | | | | | | 10d. INSIDE CITY LIMITS? 1 XYES 2 NO |
| FUNERAL | 100. STREET AND NUMBER 109 ELM STREET | | | 10 | ZIP CODE | | | | | S. | VHAT COUNTRY? |
| | 11. MARITAL STATUS 1 Never Married 2 Married FORCES? 1 IF YES, GIVE W | T EVER IN U.S. ARMED | | If yes, sp | ecify Cuba | n, Maxica | IC ORIGIN? (Sp n, Puarto Rican | | or No- | Black | E — American Indian, k, Whita, atc. |
| B | 3 Wildowed 4 Divorced | AR OR DATES | | 1 U YES | 2 (NO | Specify | * | | | Speci | "WHITE |
| 입 | 15. DECEDENT'S EDUCATION | 18a. DECEDER | NT'S USUA | L OCCUPATION | ON | | 16b. KIND | OF BUSI | NESS/IN | DUSTRY | *************************************** |
| COMPLETED | (Specify only highest grade completed) Elementary/Secondary (0-12) College (t-4 or 5 | life Do No | d of work do OT use retire | one during mo od.) | st of workin | 9 | | | | | |
| 릴 | 5 | | TODI | AN | | | RIE | BON | CO | MPAN | ٧Y |
| ő | 17. FATHER'S NAME (First, Middle, Last) | | | | ts. MOTH | IER'S NAI | ME (First, Middle | , Maiden S | urneme) | | |
| BE | HARRY | BENT | Z | | CO | RA | MAE | | TU | CKE | R |
| | t9e. INFORMANT'S NAME (Type/Print) | 19b. MAI | LING ADDR | ESS (Street a | nd Number | or Aural F | loute Number, Ci | ty or Town, | State, Zi | p Code) | |
| 2 | DONNA M. BENTZ | 109 | ELM | STRE | ET, H | IAGEF | RSTOWN, | MAR | YLAN | √D 21 | .740 |
| | 20a, METHOD OF DISPOSITION t X Burlai 2 Cremation 3 Ramoval from Stata 4 Donafion 5 Other (Specify) | 206. PLACE AND D. RUSE HIL | | | | 08- | -23-94 | | | City or To | WIN, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | 22. NAME A | D ADDRES | SS OF FAC | CILITY | | | | |
| | · R. hoal Bras | | | | | | | | | | INC. WN,MD. 21740 |
| | 23. PART I. Entar tha diseasea, or complications the shock, or heart fallurs. List only one car | Caused the death. | Do not en | itar tha mo | de of dyl | ng, sucl | n as cardiac | or reapire | ntory ar | rest, | Approximate interval Between |
| | IMMEDIATE CALIFE (Float | Charles Laborator | ont | n (9) | 2 | 1 | 200 i 000 | 27.0 | | | Onest and Death |
| | resulting in death) a. DUE TO | (OR AS A CONSEQUENC | CE OF): | 1 | 30-7 | | / 20 | Ψ | | | 11000 |
| NO | Sequentially list conditions, b. Due To | (OR AS A CONSEQUENCE (OR AS A CONSEQUENCE | SOFT | rect | ive | pu | lecon | 4 | Dig | ea | year |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | (| | | |
| E | that initiated events | (OR AS A CONSEQUENC | CE OF): | | | | | | | | |
| ᇤ | resulting in death) LAST | | | | | | | | | | |
| | PART II. Other significant conditions contributing to | death but not regult | ing in the | derbile | | Color In | Deat Las | | | T.,, | |
| DICAL | TAIT II. Other agrillound continue contributing to | Gaatri Dut not rasurt | ing in tha | undariyin | g causa g | givan in | Part I. 24a. | WAS AN A | | 24b. | . WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| ă | | | | | | | ' [| YES 2 [| MO | | OF DEATH? |
| ME | | - | | | | | | | | | 1 YES 2 NO |
| Z | DID TOBACCO USE CONTRIBUT | E TO CAUSE | OF D | EATH | YES [| N | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | | OTA | 28. PI | ACE OF D | EATH (Che | ock only one) | | | | |
| ΥS. | 1 TES 2 TO 1 Input lant 2 9 | ER/Outpatient 3 DO | | | e 5 🗆 Re | sidence | 8 Other (Spe | icify) | | | |
| H | 27. MANNER OF DEATH 28a. DATE OF (Month, L.) 1 Natural 5 Pending | | TIME OF | | URY AT | | 28d. DEŞCRIB | E HOW IN. | JURY OC | CURED | |
| B | 2 Accident Investigation | | , A | 1 🗆 | | NO | | | | | |
| | 3 Suicide 8 Could not be 4 Homicide detarmined | OF INJURY — At home, fe atc. (Specify) | erm, straet, | factory, offic | • | | 28t. LOCATION City or Tow | | d Numbe | r or Rural F | Route Number, |
| ١٣ | 29a. CERTIFIER Check only CERTIFYING PHYSICIAN: To the best of | my knowledge death of | coursed at a | So the collect | and plans | and do | | 15 | | 170 | |
| COMPLETE | (Check only one) 2 MEDICAL EXAMINER: On the besis of e | | | | | | | | | | and menner as stated |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | | | | | |
| H | OV. | | | | 29c. LICE | NSE NUN | IBER | | 29d. DAT | SIGNED | (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAU | SE OF SEATH OVER OF | (Ame Dist | | 1 | (4) | -/ | | - 2 | 123 | 179 |
| | ABOUL WHITE | 2 419- | | 21_0 | DAK | Hi | (AVE | H | 44/2 | RST | form ung |
| | | AR'S SIGNATURE | | | | | | | | | |
| - 1 | AUG 24 1994 Julie | Jenism Rand | - | | | | | | | | |

BALTIMORE, MARYLAND 21215-0020 § DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within property float of the form of the retained by the intending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.



| | O DE COMPI ETED DV DUVOIONAM, MEDIOA, OFFITTION |
|---|---|
| examiner must be notified at once. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| he funeral director, page 5 should be detached al. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| ir death. Page 6 may be retained by the hosp | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp |
| | |

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
|---|----------|
| CERTIFICATE OF DEATH | REG. NO. |

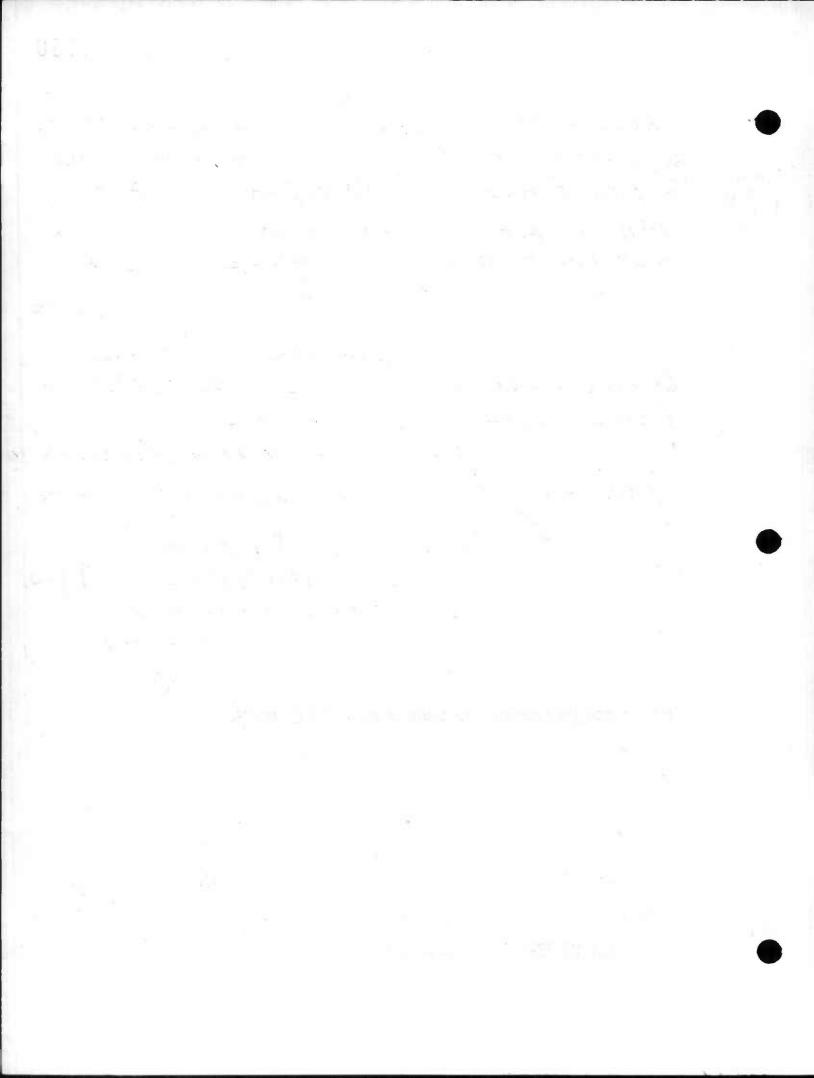
| | 1 - FOR STATE REGISTRAR | | / DEPARTM | | | MENTAL HYGIEN | | |
|------------------|--|--|--|-------------------|--------------------------------------|---|---------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | BETTY L. BYERS | | | | | AUG 25 | | 10:30P M |
| i | 4. SOCIAL SECURITY NUMBER 5. SEX | 6. AGE (In yrs. In | | NDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 6. BIRT | HPLACE (State or Foreign |
| | 213-16-0577 1 M 2 [| ^ | YRS. MON | | HOURS MIN. | (Month, Day, Year) 8-20-1933 | 3 Ma: | ryland |
| æ | 9e. FACILITY NAME (If not institution, give street and numb WASHINGTON COUNTY | | 9b. | | RSTOWN | EATH | 9c. COUNTY OF I | DEATH NGTON |
| CTC | RESIDENCE OF DECEDENT | | | | | | <u> </u> | |
| DIRECTOR | 10e. STATE 10b. COUNTY | | | WN OR LOCAT | ION | | | 10d. INSIDE CITY LIMITS? |
| | Maryland Washington | n | Hager | stown | | | | 1 TES 2 NO |
| FUNERAL | 17606 Homewood Road | | | 101. | 21740 | | U.S.A. | WHAT COUNTRY? |
| S | | CEDENT EVER IN U.S. A | | | ENDENT OF HISPAN | NIC ORIGIN? (Specify Yea | or No- 14. RAC | E — American Indian, |
| ВУ Е | | ? 1 TYES 2 X GIVE WAR OR OATES | INO | | city Cuban, Maxica 2 X NO Specify | n, Puerto Rican, atc.) y: | Spec | ck, White, etc. |
| | 15. DECEDENT'S EDUCATION | 14. 5 | FORDENITIO HOU | | | 1 | | White |
| COMPLETED | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1- | ((| ECEDENT'S USUA Give kind of work of a. Do NOT use reti | done during mos | n of working | 16b. KIND OF BUS | SINESS/INDUSTRY | |
| PL | 12 years | (OV 5 +) | | | | Bankir | ng | i |
| SON | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Malden | Surname) | |
| BE (| Paul R. Byers Sr. | | | | 0. | Louise | Gilbe | ert |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or Town | | |
| - | Paul R. Byers Jr. | | | | | gerstown, M | | 21742 |
| | 1 St Burlel 2 Cremetion 3 Removal from Sta 4 Donation 5 Other (Specify) | cemetery, cr | ematory or other p | iace) Nom D | neof | -1994 Hage | CATION — City or T | Mouse 3 |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | Cedai | . Dawii i | 22. NAME AN | D ADDRESS OF FA | CILITY | | |
| | Douglo & Fil | | | Dougl | as A. Fi | lery 1331 | Eastern | Blvd. North |
| | 23. PARTY, Enter the diseases, of complication | s that coursed the d | esth. Do not e | nter the mo | de of dying, suc | Hagersto | own, Mary | /Land Approximate |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) | | | Jenos | CLENOT | 10 CAMPI | JUDSau | interval Between Onset and Death |
| _ | | DISOTAS O | | | | | | |
| Š | | UE TO (OR AS A CONSE | | | | | | |
| SA | cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | |
| 티 | that initiated events resulting in death) LAST | UE TO (OR AS A CONSE | OUENCE OF): | | | | | |
| CERTIFICATION | d | | | | | | | |
| AL (| PART ii. Other significent conditione contributi | ng to deeth but not | resulting in th | e underlying | ceuse given in | Part i. 24s. WAS AN | | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| PHYSICIAN: MEDIC | | | | | | 1 ES 2 | MICO! | COMPLETION OF CAUSE DF OEATH? |
| ME | | | | | | | | 1 _ YES 2 _ NO |
| AN | DID TOBACCO USE CONTRIBUTE TO 25. WAS CASE REFERRED TO MEDICAL | | | | UNCERTAI | V 🗆 | | |
| SICI | EXAMINER? HOSPITA | L: | CE OF DEATH (C | HER: | . 6 | TAR WATER | | |
| HX | 27. MANNER, OF DEATH 28a. DA | TE OF INJURY | 28b. TIME OF | 28c. INJU | JRY AT | 6 Other (Specify) 28d. DESCRIBE HOW IN | JURY OCCURED | |
| ВУ Р | 1 Pending 2 Accident investigation | onth, Day, Year) | INJURY | M 1 N | RK? ES 2 NO | | | |
| | 3 Suicide a Could not be 28e. PL | ACE OF INJURY — At he liding, atc. (Specify) | ome, farm, street. | , fectory, office | 7 | 28f. LOCATION (Street a City or Town, State) | and Number or Rural | Floute Number, |
| COMPLETED | | | | | | | | |
| MPL | 29e. CERTIFIER (Check only one) | | | | | | | |
| 8 | 2 MEDICAL EXAMINER: On the bas | is of examination end/or | Investigation, in | my opinion, de | eth occured at the | time, deta and piece, and | d due to the cause(| s) and manner as stated. |
| BE | 296. AGNATURE AND TITLE OF ORNTHINER | 0) | | | 29c. LICENSE NUM | | N . | O (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED | CAUSE OF DEATH (ITE | EM 27) (Type, Print | , | 0.0. | M.E. | AU | IG 26/94 |
| Ì | 5 46 4 | | | | eet, Ba | ltimore, | Maryla | and 21201 |
| | 31. DATE FILEO (Month, Day, Year) 32/15/0 | ISTRABIS SIGNATURES | | | | | | |
| | AUG 3 0 1994 | | | | | | | |

| detache | | tem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|---|---|
| 8 | | To |
| should | | otified |
| 2 | | ĕ |
| page | | l be |
| director, | | Pr mus |
| DIRECTOR: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 5 should be deta | | xamine |
| å, | oval. | 9 |
| 5 | rem | edic |
| pe | ٦, ٥٢ | E |
| aly fi | ation | nt, the |
| omplete | I, crem | event |
| and Ci | o buria | natic |
| ysician | nours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | trau |
| ing ph | ygiene | other |
| Hend | HIE | 0 |
| the a | Men | nju |
| d S | and | ny i |
| Signe | Health | WS a |
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| Jas b | Dept | 23 |
| cate | State | неш |
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| Affer | death | E |
| 10R: | after | 28 1 |
| DIREC | OURS | tem : |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPAR CERTIF | TMENT OF H | EALTH AND I | MENTAL HYGIEN | | |
|---------------|--|--|-------------------------------|--|-----------------------------|---|---------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 1 NAN | | Ben | son | 2. DATE OF DEATH | 6/9 | YEAR 1915 M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (1) | in yrs. last birthday) 4 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Oct. 19 1 | 000 | BIRTNPLACE (State or Foreign Country) |
| œ | 9a. FACILITY NAME (If not institution, give s | | | | OR LOCATION OF DE | | 9c. COUNT | Guseman, W. Va. |
| CTO | Homewood Retirem | | | - | amsport | | Wash | ington |
| DIRECTOR | W. Va. | Y | | organtov | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| RAL | 10s. STREET AND NUMBER | | | 101 | . ZIP CODE | | | N OF WHAT COUNTRY? |
| FUNERAL | 833 Monongalia A | 12. WAS DECEDENT EVER IN | U.S. ARMED | 13. WAS DEC | 26505 ENDENT OF HISPAN | IIC ORIGIN? (Specify Ye | U.S. | A . 4. RACE — American Indian, |
| B | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 YES | 2 NO | If yes, sp | 2 NO Specify | n, Puarto Rican, etc.) | | Specify: White |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5+) | | USUAL OCCUPATION CONTROL OCCUPAT | | 16b. KIND OF BU | SINESS/INDUS | TRY |
| OMP | 9 17. FATNER'S NAME (First, Middle, Lest) | | Homema | ker | 18 MOTNED'S NA | Her ME (First, Middle, Maiden | own ho | me |
| BE C | Jesse Michael En | glehart | | | III. WOTHER S HAI | Sarah Gra | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) Fred Jenkins Fune: | rol Homo | 1 | | | Noute Number, City or Tox | | |
| | 20s. METHOD OF DISPOSITION 1 Burlel 2 Cremetton 3X Rem | 20b. | PLACE AND DATE O | F DISPOSITION (Na | | DATE 20c. LC | | 26505 by or Town, State |
| | 4 Donation 5 Other (Specify) | C | entenary entenary | Cemeter | y 8-30 | | ston C | ounty, W. Va. |
| | - 1 | Vistel | | | | | | neral Home yn, MD 21740 |
| | 23. PART I. Enter the diseases, or cahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. Motas | the death. Do not line. | 600 | | as cardiac or resp | | t, Approximate interval Between Onset and Death |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | с | CONSEQUENCE OF | | | | | |
| MEDICAL | PART II. Other eignificant condition | a contributing to death bu | ut not reaulting in | n tha underlying | g cause given in (| Part I. 24a. WAS AN PERFOI | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| S | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 26. PL | ACE OF DEATH (Che | ick only one) | | |
| PHYSICIAN: | 1 Tes 2 No 27. MANNER OF DEATN | 1 Inpetient 2 ER/Outpet 28a. DATE OF INJURY | 28b. TIME | 4 Mursing Home | | 8 Other (Specify) 28d, DESCRIBE NOW I | NJURY OCCUF | RED |
| BY | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJ | M 1 🗆 Y | ES 2 NO | | | |
| ETED | 3 Suicide 6 Could not be detarmined | 28a. PLACE OF INJURY building, atc. (Speci | — At home, farm, s | treet, factory, office | | 28f. LOCATION (Street City or Town, State) | and Number or | Rural Route Number, |
| COMPLET | | CIAN: To the best of my knowle R: On the basis of examination | | | | | | |
| W | 296. SIGNATURE AND TITLE OF CERTIFIE | | | | 29c. LICENSE NUM | 6806 | 29d. DATE 6 | COMED MOVER, COL MANY |
| 2 | 30. NAME AND ADDRESS OF PERSON WH | 12821 6 | TN (ITEM 27) (Type) | // De | - Hes | entou | nn | 21742 |
| | 31. DATE FILED (MOTH) Day YOU! 1994 | 32. MEGISTRAR'S SIGNA | TURE HULLER | | 1 | | | |

| - Julian | | permit. | .r |
|---|--|---|--|
| April 1 | Liter St | ansit | Property of |
| BALTIMORE, MARYLAND 21215-0020 | nours after death. Page 6 may be retained by the hospital or attending physician | led in by the funeral director, page 5 should be detached for use as the burial-tra, or removal. | medical examiner must be notified at once. |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within nours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transfignermit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: It Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. |
|------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) HELEN MARIE BOYKO 2. DATE OF DEATH MONTH DAY YEAR 7: 45A M |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) F UNDER I YEAR F UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) Ountry) 8. BIRTHPLACE (State or Foreign Country) NO NO NO NO NO NO NO NO NO N |
| TOR | 98. FACILITY NAME (If not inelitution, give street and number) 299. MAPLE AVE PASADENA 9c. COUNTY OF DEATH A, A, RESIDENCE OF DECEDENT |
| DIRECTOR | 106. STATE 106. CITY, TOWN OR LOCATION PASADENA 106. INSIDE CITY LIMITS? 1 VES 2 NO |
| FUNERA | 10a, STREET AND NUMBER 209 MAPLE AVE 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? VSA |
| BY FU | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WIdowed 4 Divorced 14. RACE — American Indian, Black, White, atc. Specify: 15. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puarto Rican, etc.) 16. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puarto Rican, etc.) 17. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puarto Rican, etc.) |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4 or 5+) 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ATM EMOCKLO |
| BE COM | 17. FATHER'S NAME (First, Middle, Lest) Dernard Lvd+Ke 18. MOTHER'S NAME (First, Middle) Malden Surreme) ETHER'S NAME (First, Middle) Malden Surreme) |
| 2 | 196. INFORMANT'S NAME (TyperPrint) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Some AS # 10 |
| | 20e, METHOD OF DISPOSITION 1 OC Burlet 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of pemeritary cremetify or other place) 3 Removal from State 20c. LOCATION — City or Town, State 3 Removal from State |
| - 5 | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Barranco Severnalk, on D 21146 |
| | 23. PÁRT I. Enter the diseasea, Dr complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, Dr heart failure. List only one cause Dn each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. A + Z |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury cause). |
| ERTIFI | that initiated eventa reaulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): |
| A | PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO NO. 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Chackers) (One) |
| IYSIC | EXAMINER? 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 286. DATE OF INJURY |
| BY P | 1 Natural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO |
| ETED | 4 Homicida determined building, stc. (Specify) City or Town, State) |
| COMPL | 29s. CERTIFIER (Check only one) 2 |
| 10 BE | 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Munth, Only, Hear) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF PRAPER (TEM 27) (Type, Print) |
| | 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE |
| | AUG 25 1994 Juli Standar Radell |

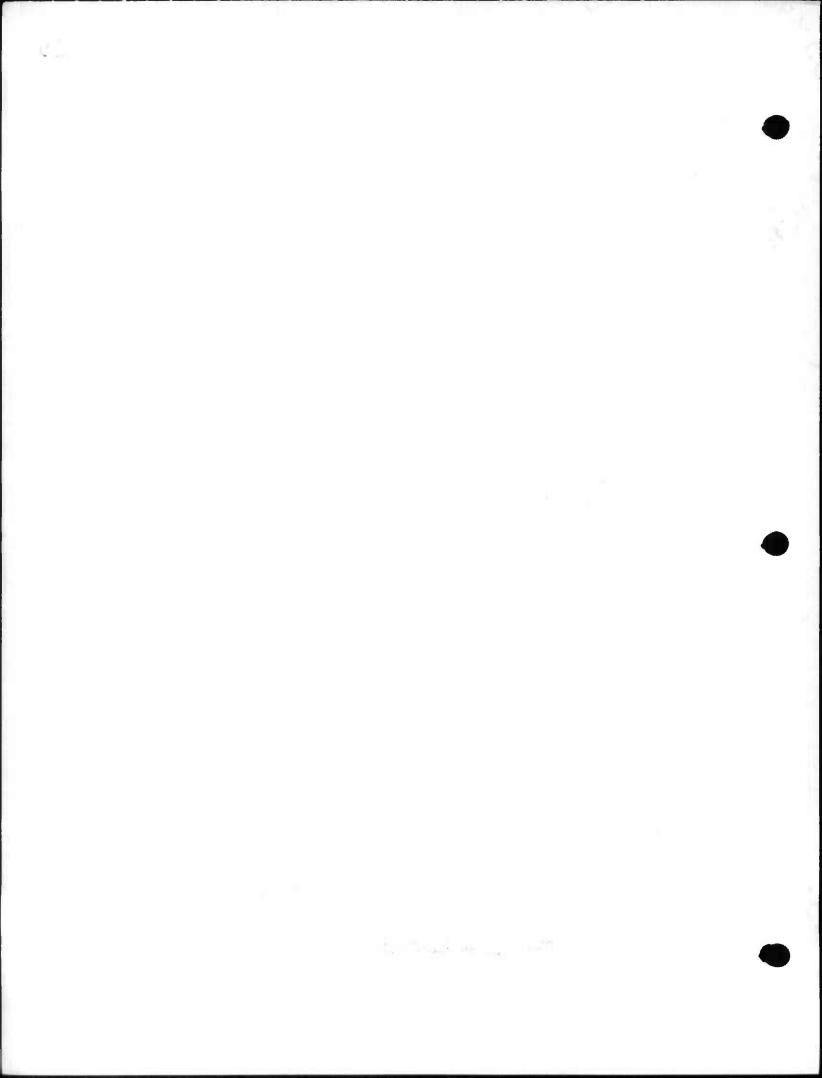


FOR

THE WAY

| DIVISION OF VITAL RECORDS, P.O. BOX 68760, TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 22 Thours after death. Page 6 may be retained by the hospital or attending physician | BALTIMORE, MARYLAND 21215-0020 mous after death. Page 6 may be retained by the hospital or attendion physician |
|---|--|
| TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal. | ed in by the funeral director, page 5 should be detached for use as the burial transit or removal. |
| IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | medical examiner must be notified at once. |
| | |

| | 1 - REGISTRAR | | CERTII | FICATE O | F DEATH | REG. NO | | | | | | | | | |
|------------------------------------|---|--|--|---|---|---|---|--|--|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | | | | | |
| 1 | Ruth | Elva | Breneman | | | August 19 | August 19, 1994 YEAR | | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | S. AGE (In yrs. lest birthday | IF UNDER 1 YEAR | R IF UNDER 24 HMS. | 7. DATE OF BIRTH | | RTHPLACE (State or Foreign | | | | | | | |
| | 212-38-8393 | 1 🗆 M 2 💢 F | 77 YRS. | MONTHS DAY | B HOURS MIN. | Sept. 22, | Co | Pennsylvania | | | | | | | |
| | 9e. FACILITY NAME (If not institution, give s | treet and number) | | 96. CITY, TOW | N OR LOCATION OF D | | 9c. COUNTY O | | | | | | | | |
| 5 | 10 Ford Circle | | Annap | | | 20 - 100-11 | | | | | | | | | |
| 5 | 10 Ford Circle | | Aillia | 0115 | | Anne | Arundel | | | | | | | | |
| H | 10e. STATE 10b. COUNTY | | TY, TOWN OR LO | | | | 10d. INSIDE CITY | | | | | | | | |
| ā | Maryland Anne Arundel | | | nnapolis | | | | 1 XXES 2 NO | | | | | | | |
| AL | 100. STREET AND NUMBER | | | | 10f. ZIP CODE | | 10g. CITIZEN O | F WHAT COUNTRY? | | | | | | | |
| FUNERAL DIRECTOR | 10 Ford Circle | | | | 21401 | | Unite | ed States | | | | | | | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT | | 13. WAS D | ECENDENT OF HISPAI | NIC ORIGIN? (Specify Yes | or No- 14. R | ACE — Americen Indian, leck, White, etc. | | | | | | | |
| ВУ | 1 Never Married 2 Merried 3 Wildowed 4 Divorced | IF YES, GIVE WAI | XYES 2 NO | | epecify Cuban, Mexica ES 2 XXO Specif | | _ Sc | necify: | | | | | | | |
| | | | | ! | | | Cai | ucasian | | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | completed) | (Give kind of | work done during | ITION most of working | 16b. KIND OF BUS | SINESS/INDUSTRY | | | | | | | | |
| Ľ | Elementary/Secondary (0-12) | College (1-4 or 5+) | Iffe. Do NOT | e and it | | NA: L: A. | | | | | | | | | |
| ¥ | | | Army Nu | se | | Milita | | | | | | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) James E. Breneman |) | | | | AME (First, Middle, Maiden a Griffith | Sumame) | | | | | | | | |
| BE | | 1 | | | | | | | | | | | | | |
| ဥ | 190. INFORMANT'S NAME (Type/Print) Betty G. Breneman | | | | | Route Number, City or Tow. | | | | | | | | | |
| | | 1 | | | | | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION 1XXBurlel 2 Cremation 3 Remo | oval from State | 206.PLACE AND DATE | | | DATE 20c. LO | CATION — City or | Town, State Township, Pa. | | | | | | | |
| | 4 Donation 5 Other (Specify) | | TWW Harrin | | | 1 | | | | | | | | | |
| | 21. SIGNATORE OF FOREBAL SERVICE | 7/// | // | 22. NAME | AND ADDRESS OF FA | CIUTY John M. T | aylor Fun | eral Home, Inc. | | | | | | | |
| | Melon | . 60 | Su . | 147 D | uke of Gloux | æster St. An | napolis, l | Vd. 21401 | | | | | | | |
| | 23. PART i. Enter the diseases, or o | complications that of | caused the deeth. Do | not enter the r | node of dying, auc | h as cardiac or respi | ratory errest, | Approximate | | | | | | | |
| | ahock, or heart fallure. I | List only one cause | on each line. | | | | | Interval Between Onset and Death | | | | | | | |
| | disease or condition | CA | ROID-DU | MONA | AN ARL | 2557 | | | | | | | | | |
| | a. CAPDIO - PUMONOMY MONTST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | |
| z | CHC | | | | | | | | | | | | | | |
| 유 | Sequentially list conditions, if any, leading to immediate | R AS A CONSEQUENCE (| | | | | | | | | | | | | |
| | cause. Enter UNDERLYING | | | CHENCE OF | | | | | | | | | | | |
| CAT | CAUSE (Disease or injury | | that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| TIFICAT | CAUSE (Disease or injury that initiated events | DUE TO (O | R AS A CONSEQUENCE O | r-): | | | resulting in death) LAST | | | | | | | | |
| ERTIFICAT | CAUSE (Disease or injury | DUE TO (O | R AS A CONSEQUENCE (| n-): | | | | | | | | | | | |
| L CERTIFICATION | CAUSE (Disease or injury that initiated events resulting in death) LAST | d | | | ing cause given in | Dart i 240 MMC AM | ALCTOREY A | | | | | | | | |
| CAL CERTIFICAT | CAUSE (Disease or injury that initiated events | d | | | ing ceuse given in | Part I. 24e. WAS AN PERFOR | | 4b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO | | | | | | | |
| DICAL | CAUSE (Disease or injury that initiated events resulting in death) LAST | d | | | ing ceuse given in | Part I. 24a. WAS AN PERFOR | MED? | | | | | | | | |
| MEDICAL | CAUSE (Disease or injury that initiated events resulting in death) LAST | d | | | ing ceuse given in | PERFOR | MED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | | | | | |
| MEDICAL | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algorificant condition | d | | in the underly | | PERFOR | MED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | | | |
| MEDICAL | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent condition. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | a contributing to de | eath but not reaulting | in the underly | ing ceuse given in | PERFOR | MED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | | | |
| MEDICAL | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent condition. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | a contributing to de HOSPITAL: Description Descripti | eath but not resulting | in the underly 26. OTHER: 4 □ Numing H | PLACE OF DEATH (Ch | PERFOR 1 YES 2 eck only one) 8 Other (Specify) | MED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | | | |
| PHYSICIAN: MEDICAL | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent condition. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | a contributing to de | eath but not reaulting | In the underly 26. OTHER: 4 Norsing He BE OF 28c. I | PLACE OF DEATH (Ch | PERFOR 1 YES 2 | MED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | | | |
| BY PHYSICIAN: MEDICAL | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Retural 5 Pending Investigation | HOSPITAL: 1 Inpetient 2 E 28e. DATE OF IN (Month, Dey. | eath but not resulting | OTHER: 4 Nursing H BE OF 28c. I JURY M 1 | PLACE OF DEATH (Ch | PERFOR 1 YES 2 eck only one) 8 Other (Specify) 28d. DESCRIBE HOW II | MED? NO | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | |
| BY PHYSICIAN: MEDICAL | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending | HOSPITAL: 1 Inpetient 2 E 28e. DATE OF IN (Month, Dey. | eath but not resulting | OTHER: 4 Nursing H BE OF 28c. I JURY M 1 | PLACE OF DEATH (Ch | PERFOR 1 YES 2 eck only one) 8 Other (Specify) | MED? NO | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | |
| BY PHYSICIAN: MEDICAL | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent condition. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: 1 Inpetient 2 Eas. DATE OF IN (Month, Day, 28s. PLACE OF I building, etc.) | eath but not resulting ER/Outpatient 3 □ DOA JURY 28b, Til NJURY — At home, farm, 2. (Specify) | 26. OTHER: 4 \(\text{Nursing M} \) 1 \(\text{street, fectory, of} \) | PLACE OF DEATH (Ch ome 5 Residence NJURY AT WORK? YES 2 NO | PERFOR 1 YES 2 ack only one) a Other (Specify) 26d. DESCRIBE HOW II City or Town, Stete) | MED? NO NO NO NO NUMBER OF RUN | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | |
| BY PHYSICIAN: MEDICAL | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: Impetent 2 = 28e. DATC OF In building, etc. | ER/Outpatient 3 DOA JURY 28b. Til Year) NJURY — At home, farm, c. (Specify) | 26. OTHER: 4 Nursing H IE OF 28c. I JURY M 1 treet, fectory, of | PLACE OF DEATH (Chome 5 Residence NJURY AT NORK? YES 2 NO fice | PERFOR 1 YES 2 ack only one) a Other (Specify) 26d. DESCRIBE HOW II City or Town, Stete) | MED? NO NO NUMBER OF RUE | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | |
| BY PHYSICIAN: MEDICAL | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: Impetent 2 = 28e. DATC OF In building, etc. | ER/Outpatient 3 DOA JURY 28b. Til Year) NJURY — At home, farm, c. (Specify) | 26. OTHER: 4 Nursing H IE OF 28c. I JURY M 1 treet, fectory, of | PLACE OF DEATH (Chome 5 Residence NJURY AT NORK? YES 2 NO fice | PERFOR 1 YES 2 ack only one) a Other (Specify) 26d. DESCRIBE HOW II City or Town, Stete) | MED? NO NO NUMBER OF RUE | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | |
| COMPLETED BY PHYSICIAN: MEDICAL | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: 1 Inpetient 2 E 28e. DATE OF IN (Month, Dey, 28e. PLACE OF I | ER/Outpatient 3 DOA JURY 28b. Til Year) NJURY — At home, farm, c. (Specify) | 26. OTHER: 4 Nursing H IE OF 28c. I JURY M 1 treet, fectory, of | PLACE OF DEATH (Chome 5 Residence NJURY AT NORK? YES 2 NO fice | PERFOR 1 YES 2 ack only one) 8 Other (Specify) 26d, DESCRIBE HOW II 28t, LOCATION (Street and City or Town, Steet) to the cause(e) and mentime, date end place, end | MED? NO NO NO NO NO NO NO NO NO N | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | |
| BE COMPLETED BY PHYSICIAN: MEDICAL | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent condition. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: 1 Inpatient 2 E 28e. DATE OF IN (Month, Day, 28e. PLACE OF I building, etc. | eath but not resulting (R/Outpatient 3 □ DOA JURY Year) 28b. Til NJURY — At home, farm, c. (Specify) y knowledge, death occur mination end/or investigati | 26. OTHER: 4 □ Nursing M HE OF JURY M 1 □ street, fectory, of ed at the time, do on, in my opinion | PLACE OF DEATH (Chome 5 Residence NJURY AT NORK? YES 2 NO fice site end place, end due, death occured at the | PERFOR 1 YES 2 ack only one) 8 Other (Specify) 26d, DESCRIBE HOW II 28t, LOCATION (Street and City or Town, Steet) to the cause(e) and mentime, date end place, end | MED? NO NO NO NO NO NO NO NO NO N | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO No Route Number, | | | | | | | |
| COMPLETED BY PHYSICIAN: MEDICAL | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation Investigation a Could not be determined 29. CERTIFIER (Check only one) 2 MEDICAL EXAMINER | HOSPITAL: 1 Inpettent 2 EB. DATE OF IN (Month, Day, 28e. PLACE OF I building, etc. CIAN: To the best of m. R: On the best of example of exa | eath but not resulting (R/Outpatient 3 □ DOA JURY Year) 28b. Til NJURY — At home, farm, c. (Specify) y knowledge, death occur mination end/or investigati | 26. OTHER: 4 Numing H BE OF 28c. I JURY M 1 street, fectory, of the time, do on, in my opinion | PLACE OF DEATH (Ch. Dome 5 Residence NJURY AT NORK? YES 2 NO fice atte end place, end due, death occured at like 29c. LICENSE NUM | PERFOR 1 YES 2 ack only one) 8 Other (Specify) 26d. DESCRIBE HOW II 28t. LOCATION (Street a City or Town, Stete) to the cause(e) and men time, date end place, en | MED? NO NO NO NO NO NO NO NO NO N | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO No Route Number, | | | | | | | |
| BE COMPLETED BY PHYSICIAN: MEDICAL | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent condition. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: 1 Inpatient 2 E 28e. DATE OF IN (Month, Day, 28e. PLACE OF I building, etc. | eath but not resulting (R/Outpatient 3 □ DOA JURY Year) 28b. Til NJURY — At home, farm, c. (Specify) y knowledge, death occur mination end/or investigati | 26. OTHER: 4 Numing H BE OF 28c. I JURY M 1 street, fectory, of the time, do on, in my opinion | PLACE OF DEATH (Ch. Dome 5 Residence NJURY AT NORK? YES 2 NO fice atte end place, end due, death occured at like 29c. LICENSE NUM | PERFOR 1 YES 2 ack only one) 8 Other (Specify) 26d. DESCRIBE HOW II 28t. LOCATION (Street a City or Town, Stete) to the cause(e) and men time, date end place, en | MED? NO NO NO NO NO NO NO NO NO N | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO No Route Number, | | | | | | | |
| BE COMPLETED BY PHYSICIAN: MEDICAL | CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent condition. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: 1 Inpettent 2 EB. DATE OF IN (Month, Day, 28e. PLACE OF I building, etc. CIAN: To the best of m. R: On the best of example of exa | eath but not resulting ER/Outpatient 3 DOA JURY Year) 28b. TH IN NJURY — At home, farm, c. (Spec/ly) y knowledge, death occur nination end/or investigati OF DEATH (ITEM 27) (Typ. | 26. OTHER: 4 Numing H BE OF 28c. I JURY M 1 street, fectory, of the time, do on, in my opinion | PLACE OF DEATH (Ch. Dome 5 Residence NJURY AT NORK? YES 2 NO fice atte end place, end due, death occured at like 29c. LICENSE NUM | PERFOR 1 YES 2 ack only one) 8 Other (Specify) 26d, DESCRIBE HOW II 28t, LOCATION (Street and City or Town, Steet) to the cause(e) and mentime, date end place, end | MED? NO NO NO NO NO NO NO NO NO N | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO No Route Number, | | | | | | | |



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| and the same | Fare and the | Est. |
| BALTIMORE, MARYLAND 21215-0020 | Thours after death. Page 6 may be retained by the hospital or attending physical or after order or attending physical order or use as the burial. | e medical examiner must be notified at once. |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Thours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL USE STORING CONTROL OF A LOCAL MASSIVE AND A L | be med writin 12 hours after death with the State Dept. Of regard and mental righers prior to burds, chemistor, or removes. IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

Dr. J. Patra.
31. DATE FILED (MOUTH), Day, Day,

Patrick Jarboe,

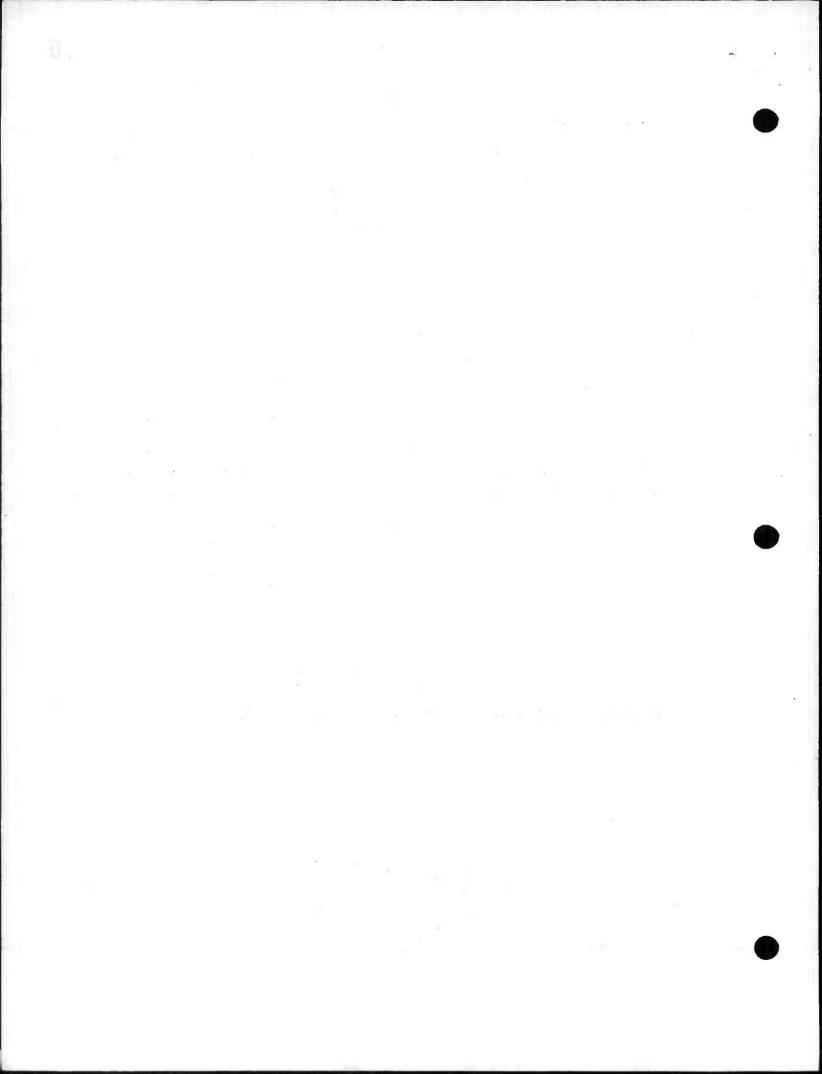
M.D

30. NAME AND ADDRESS OF

| | | | | | | | | | | | 91 | } (| 2011 | U |
|--|--|-----------------------|------------------------------------|-------------------------|-------------|-------------|---------------|----------------|----------------|----------------------------------|-------------|-----------------|------------------|---------------------|
| | 1 - FOR STATE REGISTRAR | STATE OF N | MARYLAND / | | | | EALTH DEAT | | MENTA | HYGIEN | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | ** | | | | | | OF DEATN | MY | | 3. TIME OF DE | ATN |
| | Margaret Cle | 2 0 | Bordas | | | | | | Jul | y 22, | 1994 | YEAR | 2:30 | А. м |
| BY PHYSICIAN: MEDICAL CERTIFICATION TO BE COMPLETED BY FUNERAL DIRECTOR | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. las | t birthday) | | R 1 YEAR | IF UNDER | | 7. DATE | OF BIRTN | | 8. BIRTI | NPLACE (State or | Foreign |
| | 237-36-2330 | 1 □ M 2 🏻 F | 68 | YRS. | MONTHS | DAYS | HOURS | MIN. | | . 10, | 1926 | Count | | lina |
| - 9 | 9e. FACILITY NAME (If not Institution, give | street end number) | | | 9b. CITY | Y, TOWN C | OR LOCATIO | ON OF DE | | , | | INTY OF D | cth Carr | ша |
| TOR | St. Mary's Nursin | g Center | | | Le | onar | dtown | n | | | St | . Ma | ry's | |
| Ä | 10e. STATE 10b. COUNT | Υ | | 10c. CIT | Y, TOWH | OR LOCAT | ION | | | | | | 10d, INSIDE CI | TY |
| 5 | Maryland Princ | ce George | 's | Ве | rwyn | Hei | ghts | | | | | | LIMITS? | NO. |
| 7 | 10e. STREET AND NUMBER | | | | | | . ZIP CODE | E . | | | 10g. CIT | IZEN OF V | WHAT COUNTRY | |
| 8 | 6301 Osage Street | | | | | | 20740 | Ω | | | | .S.A | | |
| Z | 11. MARITAL STATUS | | T EVER IN U.S. AR | | | | | IIC ORIGI | N? (Specify Ve | | | E — American In | dlan | |
| | 1 Never Merried 2 Merried 3 Widowed 4 Divorced | | YES 2 X | | | | | | n, Puerto | | 01110 | Spec | k, White, etc. | |
| Ω. | 15. DECEDENT'S EDU | | 16a, DE | CEDENT'S | USUAL O | CCUPATIO | ON | | 166 | b. KIND OF BL | SINESS/INI | DUSTRY | Whit | e |
| | (Specify only highest grade Elementary/Secondary (0-12) | | (G | ive kind of Do NOT u | work done | during mo | st of workin | g | | | | | | |
| 2 | | College (1-4 or 5 | 4 | coun | tant | | | | | U.S. | Cove | rnmei | nt | |
| N | 12th_Grade 17. FATNER'S NAME (First, Middle, Last) | | 110 | cour | carre | | 40. 440774 | IEDIO NA | ME CEL | Middle, Meider | | LILIC | 110 | |
| ŏ | | Total mark | | | | | | | | _ | _ | L base or | | |
| 8 | John Watson 196. INFORMANT'S NAME (Type/Print) | Winste | | | | | | llia | | Gray | | tanc | 11 | |
| 2 | Peggy D. Burton | | 1.0 | | | | | | | ico Ro | | | icsvill | ę, |
| | 20a. METNOD OF DISPOSITION | 22 | 20b. PLACE | | | | | | | | CATION - | City or To | own, State | 9 |
| | 1 Buriel 2 Cremetion 3 Rem | ioval from State | cemetery, cre | | | | erv | 7 | /DE / | (0.4) D | | | N6 | a |
| | 21. SIGNATURE OF FUNERAL SERVICE L | CENTRE! | - I Clad | шсо | 22. | NAME AN | ID ADDRES | SS OF FA | CILITY | | | | Marylar | |
| | Mind DY | 11 | 1. | - | M | latti | ngle | y-Ga | rdir | ner Fu | neral | . Hom | e, P.A. | |
| | 11 Willaut | Hak | denes | / | P | .0. | Box 2 | 270 | Leor | nardto | wn, M | aryl | and 206 | 50 |
| | 23. PART Enter the diseases, or ahock, or heart failure. | complications the | t ceused the de | eth. Do | not enter | r the mo | de of dyl | ng, aucl | h as car | rdiec or reap | iratory ar | real, | Approxi | |
| | IMMEDIATE CAUSE (Final | List only one cau | isa on each line | 1 |) | | 1.0 | _ | 1 | | | | | Between nd Daath |
| | disease or condition | 100 | dias | -1/ | mo | 21/8/ | 1.11 | 27, | Vie | 18. | | | 160 | |
| ı | reaulting in death) | O. PUE TO | OR AS A CONSE | DUENCE O | 201 | The same | 71 | T | ~ w | VC | | | IV, | / |
| - | _ | 10 | 1 orta | 1119 | 41 | 10 | 611 | 1 |)5 | 2 | | | 41 | 1 |
| 0 | Sequentially list conditions, | DUE 10 | OR AS A CONSEC | MANCE O | 1/2 | 4 | 4 | 1 | 1 | - | | | 17 | N |
| ¥ | if any, leading to immediate cause. Enter UNDERLYING | Victorial Con | / | 1 | | ı | / | | | | | | 101 | |
| 프 | CAUSE (Disease or Injury that initiated events | DUE TO | (OR AS A CONSE | DUENCE O | F): | | / | | | | | | 1 | |
| E | resulting in deeth) LAST | | (/ | | | | | | | | | | 1 | |
| 빙 | | 0. | | | | | | | | | | | | |
| A | PART II. Other significent condition | ns contributing to | deeth but not r | esuiting | in the u | nderlying | ceuae g | given in | Part i. | 24s. WAS AF | | 24b | WERE AUTOPSY | |
| 2 | Chr | ona 1 | Kena | + | au | lu | 19 | | | 1 TYES | | | COMPLETION O | |
| Ē. | | , | | | | | | | | | | | OF DEATN? | 1 NO |
| - | DID TORACCO LISE | CONTRIBUTE | TO CALLS | E 0E | DEAT | ru v | EC [] | NO | M | | | | 114 | 7 |
| A | DID TOBACCO USE (25. WAS CASE REFERRED TO MEDICAL | TONIKIBUTE | TO CAUS | E OF | DEA | | ACE OF DE | NO EATN (Ch | | nel . | | | 11/ | / |
| 2 | EXAMINER? | HOSPITAL: | EDIO ALIAN AND A | □ no a | OTHE | R: | | | | | | | | |
| ¥ | 27. MANNER OF DEATN | 28e. DATE OF | | 28b. TIN | - | _ | e 5 🗆 Ré | sidence | _ | | | | | |
| | 1 Netural 5 Pending | (Month, D | | IN. | JURY | | RK? | | 28d. DE | SCRIBE NOW | INJURY OC | CURED | | |
| BY | 2 Accident Investigation | | | | | | /ES 2 | NO | | | | | | |
| | 3 Suicide 8 Could not be 4 Nomicide determined | building, | F INJURY — At ho atc. (Specify) | me, term, | street, fac | tory, offic | • | | | CATION (Street or Town, State | | r or Rural i | Route Number, | |
| E | | | _ | | | | | | | | | | | |
| PL | 29e. CERTIFIER (Check only | ICIAN: To the best of | my knowledge, de | ath occur | ed at the | time, date | end place, | end due | to the ce | use(s) end ma | nner ee stu | ted. | | |
| COMPLETED | one) 2 MEDICAL EXAM H | | | | | | | | | | | | s) and manner as | etelset. |
| | 295. SIGNATURE AND TITLE OF CERTIFIE | n () | # 1 | | 7 | 1/\ | 29c, LICE | NSE NUN | ance | - | 29d DAT | E SIGNED | Month, Dawing | 74 |
| BE | Ja | XI | Maria | 1 | N | / Y | D | 0 | 611 | 19 | 1 | 1-1 | 27-94 | / |
| 임 | 30. NAME AND ADDRESS OF PERIODS WE | O COMPLETED CALL | SE OF DEATH TOTAL | A TO /SE | Dried | | | 0 | DI | 1/ | / | 0 | 05// | |

Leonardtown, Maryland 20650

OHMH-16 Rev 1/89



| BALTIMORE, MARYLAND 21215-0020 | SICIAN: The law requires that the death certificate be executed within ours after death. Page 6 may be retained by the hospital or attending physician. | certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans In the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral. |
|----------------------------------|---|---|
| LTIMORE, M | ath. Page 6 may be reta | neral director, page 5 sl |
| | ours after dea | ely filled in by the funation, or removal. |
| OX 68760, | te be executed with | sician and complete |
| IDS, P.O. E | the death certifical | y the attending phy nd Mental Hygiene |
| F VITAL RECORDS, P.O. BOX 68760, | The law requires that | certificate has been signed by the attending physician and completely filled in by the the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| 7 | SICIAN | certifica |

DIRECTOR FUNERAL ВY COMPLETED BE 2 CERTIFICATION

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this c marked,

After

DIRECTOR: Afthours after de-

TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTS be filed within 72 hours at IMPORTANT: If Item 2:

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE 2 25.

1 Natural 2 Accident

3 Suicide

4 Nomicide

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) IRENE BIRCHFIELD 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday. IF UNDER 1 YEAR | IF UNDER 24 HRS.

1 M 2 XF

| REG. NO. | | |
|--|-------|------------------------------|
| 2. DATE OF DEATH MONTH DAY | YEAR | 3. TIME OF OEATN |
| JULY 22, 1994 | | 1:40 P |
| 7. DATE OF BIRTN (Month, Day, Year) MARCH 19, 1914 | Count | NPLACE (State or Foreign ry) |

9b. CITY, TOWN OR LOCATION OF DEATH

HOURS

10f. ZIP CODE

9c. COUNTY OF DEATH

ST. MARY'S NURSING CENTER LEONARDTOWN ST. MARY"S RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY

YRS.

DAYS

MARYLAND ST. MARY'S MECHANICSVILLE 10e. STREET AND NUMBER

80

1 YES 2 NO 10g. CITIZEN OF WHAT COUNTRY?

WHITE

121 OAKS ROAD 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS

20659 UNITED STATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuban, Mexicen, Puerto Rican, etc.)
1 YES 2 NO Specify:

14. RACE — American Indien, Black, White, atc.

15. DECEDENT'S EDUCATION pecify only highest grade comple (Spe Elementary/Secondary (0-12) College (1-4 or 5+)

9a. FACILITY NAME (If not institution, give street end number,

18a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)

SCHOOL TEACHER DORM DIR.

16b. KIND OF BUSINESS/INDUSTRY

UNIVERSITY

17. FATNER'S NAME (First, Middle, Last) MORT FAULKNER

JUDA MILLMAN

1 Never Married 2 Married

3 XWidowed 4 Divorced

292-14-4001

18. MOTNER'S NAME (First, Middle, Maiden Surname)

MINNIE THOMAS

19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)

121 OAKS ROAD, MECHANICSVILLE, MARYLAND 20659

20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State METROPOLITIAN CREMATORY 7/23 **VIRGINIA**

CHARLE OF FUNERAL MERVIGE LICENSE MICHAEL K. BLANKENSHIP

Investigation

8 Could not be determined

20s. METHOD OF DISPOSITION
1 ☐ Burlel 2 The Cremation 3 ☐ Removal from State
4 ☐ Departion 5 ☐ Other (Specify)

22. NAME AND ADDRESS OF FACILITY
BRINSFIELD FUNERAL HOME

P.O. BOX 279, LEONARDTOWN, MARYLAND 20650 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximata

| iMMEDIATE CAUSE (Finel disease or condition resulting in death) | ellure. List phly pne ceuse pn eech line. | lmmay Failing | , | Interval Between Onset and Death |
|--|---|--|---------------------|-------------------------------------|
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE DUE TO (OR AS A CONSEQUENCE DUE TO (OR AS A CONSEQUENCE OF TO (OR AS A | yocasdial me Artory | exolin | min |
| PART II. Other significent con | nditions contributing to death but not resulting | in the underlying ceuse given in Pert i. | 24a. WAS AN AUTOPSY | 24b. WERE AUTOPSY FINDINGS |

1 | YES 2 |

NGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?

| DID TOBACCO USE | CONTRIBUTE | TO | CAUSE | OF | DEATH | YES | | NO | |
|---------------------------------|------------|----|-------|----|-------|-----------|--------|--------|----------|
| S. WAS CASE REFERRED TO MEDICAL | | | | | | 28. PLACE | OF DEA | TN (Ch | eck only |

v one) HOSPITAL: 1 YES 2 1 Inpatient 2 ER/Outpetient 3 DOA raing Nome 5 Realdence 6 Other (Specify) 27. MANNER OF DEATH

28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED INJURY 1 YES 2 NO

28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify)

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

| 29a. (| CERTIFIER | 4 SCENTIEVING DUVENCIAN TO ALL A LA LA LA LA LA LA LA LA LA LA LA |
|--------|------------|--|
| - 6 | Check only | 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated |
| | ne) | A DISPOSAL PARAMETER OF THE PARAMETER OF |

29d. DATE SIGNED (Month, Day, Ya 28b. SIGNATURE AND TITLE OF 29c. LICENSE NUMBER

MEDICAL ARTS BLDG., LEONARDTOWN, MARYLAND 20650 21, DATE FILED /MO

1994 JUL

HOSPITAL OR ATTENDING PHYSICI

DIVISION OF

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TO THE MOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within along a first forms. Agus a may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burla-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memal Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLAN | ID / DEPARTM | | | MENTAL HYGIEN | E | |
|------------------|---|--|--|---------------------|-----------------------|---|---------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | HERBERT | LEE | CRIT | ES | | August 19 | 1994 | 4:45 Pm |
| | | . SEX 6. AGE (In y | | INDER 1 YEAR | IF UNDER 24 HRS. | 7 DATE OF BIRTH | a DIE | THPLACE (State or Foreign |
| | 234-38-8231 | ¥m2□F 65 | YRS. MON | THS DAYS | HOURS MIN. | Oct 17, 19 | 28 | WV |
| | 9e. FACILITY NAME (If not institution, give street | and number) | 9b. | CITY, TOWN C | R LOCATION OF DE | | 9c. COUNTY OF | |
| E | Memorial Hospital | | | Cumber | land | | Alleg | anv |
| DIRECTOR | RESIDENCE OF DECEDENT | | | | | | 211108 | any |
| Ш | 10a. STATE 10b. COUNTY | | | WN OR LOCAT | ION | | | 10d. INSIDE CITY LIMITS? |
| | MD Allega | any | Cumbe | erland | | | | 1 XYES 2 NO |
| 3A | 10e. STREET AND NUMBER | | | | ZIP CODE | | | F WHAT COUNTRY? |
| FUNERAL | 317 Emily Street | | | | 21502 | | USA | |
| 3 | 11. MARITAL STATUS 1 Never Merried 2 Merried | PORCES? 1 YES | S. ARMED 2 NO | 13. WAS DEC | ENDENT OF HISPAN | IC ORIGIN? (Specify Yee n, Puerto Rican, etc.) | or No — 14. RA | ICE — American Indian, ack, White, etc. |
| B | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DATE | s | | 2 X NO Specify | | Sp | white |
| | 15. DECEDENT'S EDUCATI | 1947 | le. DECEDENT'S USU | N. OCCUPATIO | NA . | 16b. KIND OF BUS | | WILLCE |
| | (Specify only highest grade con | npleted) College (1-4 or 5+) | (Give kind of work of life. Do NOT use reti | done durina mo | st of working | 160. KIND OF BOS | INCSS/INDUSTRE | |
| 7 | 12 | onege (I-4 or 5+) | Cert Exe | cutive | Chief | Count | ry Club | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Maiden | | |
| BEC | Charles E. Crit | ·es | | | | V. (Seede | . 1 | |
| | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING ADD | RESS (Street e | nd Number or Rural F | loute Number, City or Town | n, State, Zip Code) | |
| 임 | Mildred L. Crites | | 317 Emil | y Stre | et; Cumb | erland, M | 21502 | 2 |
| | 26a METHOD OF DISPOSITION 1 ♣ Burtel 2 ☐ Cremetion 3 ☐ Flamousi | | ACE AND DATE OF DE | | me of | DATE 20c. LO | CATION — City or | Town, State |
| | 4 Donation 5 Other (Specify) | Fore | ry. crematory or other p | <u>Cemete</u> | ry | 8/22 Gr | eenspri | ng, WV |
| - 1 | 21. SIGNAPORE OF FUNERAL SERVICE LICENS | 1 | | | ID ADDRESS OF FAC | | | |
| | Mans + X | 10000 | 11- | Scarr | elli Fun erland, M | eral Home D 21502 | | |
| | 23. PART i. Enter the diseases, or com | pilcations that caused to | e death. Do not a | ntar tha mp | da of dying, such | aa cardiac pr reapi | ratDry arrest, | Approximate |
| | ahock, or heart failure. Liet iMMEDIATE CAUSE (Final | only Dna caule on each | line. | | | | | intarval Batween Onset and Death |
| - 1 | disease or condition | DECOM | | _ | do de mor | | | |
| | a | DUE TO (OR AS A CO | ONSEQUENCE OF): | | - KKC 2 | | | |
| Z | Securation list conditions b | INCR | EATED | TNI | RA CA | AWIAL | TENER | 2 |
| CERTIFICATION | Sequantially flat conditions, if any, leading to immediate | DUE TO (OR AS A CO | NSEOUÉNCE OF): | | | , , , , , , | | |
| 2 | CAUSE (Disease or injury | BRA! ~ | ME | LAST | 2124 | | | |
| Ē | that initiated events resulting in death) LAST | | | | | | | |
| S | d | LUNG. | CAL | ICER | | | | |
| AL | PART ii. Other aignificant conditions c | ontributing to death but | not resulting in th | a undarlying | cause givan in | Part I. 24a, WAS AN PERFOR | | 4b. WERE AUTOPSY FINDINGS |
| | | | | | | 1 - YES 2 | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| ME | | | | | | | | 1 YES 2 DAG |
| PHYSICIAN: MEDIC | DID TOBACCO USE CO | ONTRIBUTE TO C | AUSE OF D | EATH Y | ES NO | | | |
| S | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | OSPITAL: | | | ACE OF DEATH (Che | ck only one) | | |
| YSI | | Inpatient 2 - ER/Outpatie | | HER: Nursing Hom | 5 🗆 Realdence | 8 Other (Specify) | | |
| H | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJ | URY AT RK? | 28d. DESCRIBE HOW I | JURY OCCURED | |
| B | 1 Naturel 5 Pending 2 Accident Investigation | | | | ES 2 NO | | | |
| | 3 Suicide a Could not be determined | 28a. PLACE OF INJURY — building, atc. (Specify) | At home, term, street | , 1ectory, office | | 281. LOCATION (Street a City or Town, State) | nd Number or Rura | Il Route Number, |
| | | | | | | | | |
| COMPLET | 29e. CERTIFIER (Check only one) | | | | | | | |
| ģ I | 2 MEDICAL EXAMINER: 0 | On the beale of exemination er | nd/or investigation, in | my opinion, d | eath occured at the | time, data end place, en | d due to the caus | e(a) and menner as stated. |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | TRAS | M.S. | | 29c. LICENSE NUM | BER | 29d. DATE SIGN | ED (Month, Day, Year) |
| 2 | | 5 | alle — | | D 2333 | 4 | 8/21 | 194 |
| | 30. NAME AND ADDRESS OF PERSON WHO CO | | | | | | | |
| | Dr. D. Shah, Johns | | | Idg, C | umberlan | d, MD 215 | 02 | |
| | 31. DATE FILED (Month, Day, Year) AUG 2 5 1994 | 32. REGISTRAR'S SIGNAL | Val | | | | | |
| | 700 N W 1354 | | | | _ | | | |

of they.

755, 5 8 5 DV

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.

| REGISTRAR CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | | | |
|---|--|---|--|---|--------------------------------------|-------------------------|---------------------------------------|--------------------------------------|------------------|--------------------|---|--------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF | | 3. TIME OF DEATH | | | н |
| | DAVID ELVIN | Į | CAM | 1PHOR | | | AUG. | 1 | 1 | 94 | 2312 | Рм |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6 | . AGE (In yrs. la | sl birthday) | IF UNDER 1 YEA | R IF UNDER 24 HRS. | 7. DATE OF | BIRTH | 13 | 6. BIRTH | PLACE (State or Fo | reign |
| | 216-90-7502 | 216-90-7502 1-2 M 2 □ F 26 YR | | | | HOURS MIN. | 05/19 | Pay, Year) | | Mar | vland | |
| | 9a. FACILITY NAME (If not institution, give : | street and number) | | | 9b. CITY, TOW | N OR LOCATION OF E | | 7.700 | 9c. COUN | | | |
| E C | PENINSULA REGIO | NAL MEDI | CAL C | η. | SALT | SBURY | | | WIC | WICOMICO | | |
| DIRECTOR | RESIDENCE OF DECEDENT | | -0112 | , 1 | - 01111 | BBOKI | | | MIC | 0111 | - | |
| H | 10e. STATE 10b. COUNT | | | 10c. CITY | TOWN OR LO | CATION | | | | | 10d. INSIDE CITY | |
| ۵ | | omico | | Sali | sbury | | | | 1 X YES 2 NO | | | NO |
| M | 10e. STREET AND NUMBER | | | 10f. ZIP CODE | | | 10g. CITIZ | EN OF W | HAT COUNTRY? | | | |
| | 713 Dennis Street | | | 21801 | | | | USA | 1 | | | |
| ב ב | 11. MARITAL STATUS | RMEO NO | 13. WAS E | ECENDENT OF HISPA specify Cuban, Mexic | NIC ORIGIN? | Specify Yea | or No- | 14. RACE | - American India | n, | | |
| BY FUNERAL | 1 X Never Married 2 Married 3 Widowed 4 Divorced | YES 2 K | ,,,, | | ES 2XXNO Spec | | an, arc.) | | Specif | | | |
| | | | | | | | | A | fric | an Amer | ican | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | completed) | /0 | ECEDENT'S L Sive kind of w Do NOT use | OSUAL OCCUPA Ork done during | TION most of working | 16b. K | IND OF BUS | INESS/INDU | STRY | | |
| Ľ | Elementery/Secondary (0-12) | Collega (1-4 or 5+) | | | retired.) | | | | | 4 | | |
| ME | 17. FATHER'S NAME (First, Middle, Last) | lac | orer | | | | | | 'Lun | nber Co. | | |
| | | | | | | 18. MOTHER'S N | | | , | | | |
| 8 | Alvin Camphor 19a. INFORMANT'S NAME (Type/Print) | | | | | / Jean | | | | | | |
| 2 | | | | | | et end Number or Rural | | | | , | 201 | |
| | Mary Jean Campho | or | | | | treet , Sa | | | | * | | |
| | 1 Suriel 2 Cremation 3 Rem | oval from State | cemetery, cre | AND DATE O | F DISPOSITION per place) | (Name of | OATE | 20c. LOC | ATION — C | Ity or To | wn, Stata | |
| | 4 Donetion 5 Other (Specify) | Acre | s Mem | orial Park | 8/20 | Salis | bury, | Mai | ryland | | | |
| | 21. SIGNAL OF FORENAL SERVICE CH | | 22. NAME | ANO AOORESS OF F | ICILITY 12 | 13 Je | rsey I | Road | i, Salisbu | ıry | | |
| | + alrelea | CF-10 | ller | 1 | Jolle | y Memoria | al Chai | oel - | | Mary | vland 21 | 801 |
| | 23. PART I. Entar the diseases, or ehock, or heart feilurs. | complications that c | ausad the | eath. Do no | ot enter the i | node of dying, su | ch aa cardia | c or reapir | atory arre | at, | Approxima | |
| | IMMEDIATE CAUSE (Final | List Only Ona Couse | on eech una | | | | | | | | Onset and | |
| | disease or condition resulting in death) | . Itan | aina | | | | | | | | İ | |
| | reconing in death) | DUE TO (O | R'AS A CONSE | QUENCE OF |): | | | | | | | |
| z | | b. | | | | | | | | | | |
| 2 | Sequantielly list conditiona, if eny, leeding to immediate | OUE TO (OI | R AS A CONSE | OUENCE OF | : | | | | | | | |
| CERTIFICATION | cause. Entar UNDERLYING CAUSE (Disease or Injury | c | | | | | | | | | | |
| Ξ | that initiated events | DUE TO (OI | R AS A CONSE | CONSEQUENCE OF): | | | | | | | | |
| | resulting in death) LAST | d | | | | | | | | | | |
| | PART II. Other significant condition | na contributing to da | ath but not | reaulting in | the underly | Ing cause alven is | Part I 2 | In MMC AN A | UTTOREY | 1 045 | WERE AUTOROX EX | IDWAGO |
| DICAL DICAL | | | | | in the undarlying causa givan in Par | | | I. 24a. WAS AN AUTOPSY PERFORMED? | | 240. | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE | |
| | | | | | | | — l¹ | YES 2 | □ NO | | OF DEATH? | |
| Σ | DID TORACCO LICE CONT | DIDLITE TO CALL | CE OF DEA | TII VE | | | | | | | 1 YES 2 N | 0 |
| 2 | DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL | RIBUTE TO CAU | | | | | и Ц Т | | | | | |
| PHISICIAN: ME | EXAMINER? | HOSPITAL: | | _ | OTHER: | | | | | | - | - |
| | 1XXES 2 □ NO 27. MANNER OF DEATH | 1 ☐ Inpatient 2 💢 🎉 | * | | | oma 5 Realdenca | | 77 | | | | |
| - 1 | 1 Natural 5 Pending | (Month, Day, | Year) | 28b. TIME INJU | RY | NJURY AT WORK? | 28d. DESCR | IBE HOW IN | JURY OCCU | IREO | , | |
| | 4 | 28a. PLACE OF II | -94 | | / | YES 2 NO | 200 | 100+ | 170 | 20 | ed | |
| | E _ Accordant | ZON. PLACE OF II | Specify) | me, rarm, at | raet, factory, of | fice | City or | ON (Street ar lown, State) | nd Number o | r Aurill A | oute Number, | |
| 0 | 3 Suicide 6 Could not be | building, atc | | | | | Freh | ern (| DOPPE | 12710 | in In | 16 |
| 0 | 3 Suicide 6 Could not be detarmined | building, atc | ding | | | | 100010 | | 0 11 | 1 11/11 | | ×7 ° |
| 0 | 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only) | CIAN: To the beat of my | knowledge, de | | | | to the cause | s) end manr | | | | 3/7 * |
| 0 | 3 Suicide 6 Could not be 4 Homicide detarmined | CIAN: To the beat of my | knowledge, de | | | | to the cause | s) end manr | | | and manner as st | eted. |
| COMPLEIED BY | 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only) | CIAN: To the beat of my | knowledge, de | | | | to the cause | s) end manr | dus to the | cause(s) | and manner as st | nted. |
| DE COMPLETED DI | 3 Sulcide 4 Homicide 6 Could not be determined 299. CERTIFIER (Check only one) 1 CERTIFYING PHYSI ONE) | CIAN: To the beat of my | knowledge, de | | | , death occured at the | to the cause time, data an | s) end manr | due to the | cause(s) | (Month, Day, Year) | |
| DE COMPLETED DI | 3 Sulcide 4 Homicide 6 Could not be determined 299. CERTIFIER (Check only one) 1 CERTIFYING PHYSI ONE) | CIAN: To the beat of my | knowledge, de | Investigation | , in my opinion | , death occured at the | to the cause time, data an | s) end manr | due to the | cause(s) | | |
| DE COMPLETED DI | 3 Sulcide 4 Homicide 6 Could not be determined 29e. CERTIFIER (Check only one) MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF DEWYFIELD | CIAN: To the beat of my | knowledge, de nination and/or | Investigation M 27) (Type, i | , In my opinion | , death occured at the | to the cause time, data an MBER | s) end manr d place, and | 29d. DATE | cause(s) SIGNED | (Month, Day, Year) | |
| COMPLEIED BY | 3 Suicide 4 Homicide 6 Could not be determined 29e. CERTIFIER (Check only one) MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF DETERMINE 30. NAME AND ADDRESS OF PERSON WH | CIAN: To the beat of my R: On the beats of axam | or knowledge, de innellon and/or DF OEATH (ITE 111 | M 27) (Type, I | , In my opinion | 29c. LICENSE NU | to the cause time, data an MBER | s) end manr d place, and | 29d. DATE | cause(s) SIGNED | (Month, Day, Year) | |
| DE COMPLETED DI | 3 Suicide 4 Homicide 6 Could not be determined 29e. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF SERVICE 30. NAME AND ADDRESS OF PERSON WH | CIAN: To the beat of my R: On the basis of axer | or knowledge, de innellon and/or DF OEATH (ITE 111 | M 27) (Type, I | , In my opinion | 29c. LICENSE NU | to the cause time, data an MBER | s) end manr d place, and | 29d. DATE | cause(s) SIGNED | (Month, Day, Year) | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR

| | REGISTRAR | | CERTIFIC | ATE OF | DEATH | REG. NO. | | | | | | | |
|---------------|---|---|---|--------------------|-----------------------------|---|---------------------------------|---|--|--|--|--|--|
| 10 | 1. DECEDENT'S NAME (First, Middle, Last) JOHN THOMAS | | JR. | | | 2. DATE OF DEATH MONTH DA | | 3. TIME OF DEATN | | | | | |
| 70 | 4. SOCIAL SECURITY NUMBER | | | UNDER 1 YEAR | IF UNDER 24 HRS. | 8 26 | 1994 | 9:15 a. M | | | | | |
| í | 216-09-4935 | 1 ⊠ M 2 □ F { | | NTHE DAYS | HOURS MIN. | (Month, Day, Year) 4/19/19 | Count | | | | | | |
| | 9e. FACILITY NAME (If not institution, give | | 9 | | OR LOCATION OF D | | 9c. COUNTY OF D | DEATN | | | | | |
| DIRECTOR | 1706 Doe Driv | e | | Fin | ksburg | | Carr | 011 | | | | | |
| E C | 10a. STATE 10b. COUNT | Y | 10c. CITY, T | OWN OR LOCA | TION | | | 10d. INSIDE CITY | | | | | |
| 급 | MD. Car: | roll | Fir | ksbur | g | | | LIMITS? 1 TYPES 2 TO NO | | | | | |
| FUNERAL | 1706 Doe Driv | e | | 10 | 21048 | | 10g. CITIZEN OF | WHAT COUNTRY? | | | | | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEOENT EVER FORCES? 1 YES IF YES, GIVE WAT OR D | IN U.S. ARMED 2 NO DATES | If yes, sp | | NIC ORIGIN? (Specity Yes in, Puerto Rican, etc.) y: | or No — 14. RAC Blac Spec | E — American Indien, ik, Whita, atc. | | | | | |
| | 15. DECEDENT'S EDU | JCATION WWT | 16m. DECEDENT'S US | HAL OCCUPATION | - A. | 16b. KIND OF BUS | | hite | | | | | |
| ETE | (Specify only highest grad Elementary/Secondary (0-12) | | (Give kind of world life. Do NOT use n | done during mo | ist of working | ISB. KIND OF BUS | INESS/INDUSTRY | | | | | | |
| AP | 11 | Conege (14 of 54) | manufact | urer | s rep. | Norcro | ss card | ls | | | | | |
| E COMPLETED | 17. FATNER'S NAME (First, Middle, Lest) John Thomas C | Surname) | | | | | | | | | | | |
| 38 0 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING AC | ORESS (Street o | and Number or Rural | Route Number, City or Town | 1, State, Zip Code) | | | | | | |
| 입 | Pennie M. Wei | SS | 1706 I | oe Dr | ive, Fi | lnksburg, | Md. 21 | .048 | | | | | |
| | 20a. METNOD OF DISPOSITION 1 Burlal 2 Cremetion 3 Ren | noval from State CB | b. PLACE AND DATE OF to metery, cremetory or other | place) | | 1 | CATION — City or Te | | | | | | |
| | 4 Donation 5 Onther (Specify) Druid Ridge Cemetery 8/29/94 Pikesville, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | | | | | | | | | |
| | Myers Funeral Home, 91 Willis St. Westminster, Maryland 21157 | | | | | | | | | | | | |
| | 23. PART i. Enter the diseasea, or | complications that cause | d the deeth. Do not | enter the mo | minstel de of dying, auc | h as cerdiec of reapi | retory arrest, | Approximata | | | | | |
| | IMMEDIATE CAUSE (Final | List only one cause on a | each iine. | | | | | intarval Batween Onset and Death | | | | | |
| | disease or condition reaulting in death) . Seases, Curonic ospullar | | | | | | | | | | | | |
| | DE TO OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| NO O | Sequentially list conditions, ONE TO JOR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| CERTIFICATION | if any, leeding to immediate cause. Enter UNDERLYING | | | | | | | | | | | | |
| | CAUSE (Disease or Injury that initiated events OUII TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| | resulting in death) LAST Lauler: Deptic Willer clusion. | | | | | | | | | | | | |
| | PART ii. Other significant condition | na contributing to death | but not resulting in | he underlyin | a cause given in | Part i. 24a. WAS AN | ALITOPSY 241 | D. WERE AUTOPSY FINDINGS | | | | | |
| DICAL | | | | , | | PERFOR | MED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | | | |
| MED | 1 YES 2 NO OF DEATH? | | | | | | | | | | | | |
| 2 | DID TOBACCO USE | CONTRIBUTE TO | CAUSE OF I | DEATH Y | ES NO | | | 1 YES 2 NO | | | | | |
| SA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | ACE OF OEATN (Ch | eck only one) | | | | | | | |
| Sic | 1 TES 2 SAPO | HOSPITAL: | | THER: Nursing Hom | e 5 🗆 Residenca | 6 Dether (Specify) | BOARDI | NG House | | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH 1 | 28e. OATE OF INJURY (Month, Day, Year) | 28b. TIME O | F 28c. INJ | URY AT | 28d. DESCRIBE HOW IF | JURY OCCUREO | | | | | | |
| ⋒ | 2 Accident Investigation | | | | YES 2 NO | | | | | | | | |
| TED | 3 Suicide 6 Could not be 4 Nomicide determined | building, etc. (Spe | Y — At home, ferm, stre | et, factory, offic | • | 281. LOCATION (Street e City or Town, State) | nd Number or Rural | Route Number, | | | | | |
| COMPLE | 29a. CERTIFIER (Check only | SICIAN: To the best of my know | wiedge, death occurred a | t the time, date | end place, and due | to the cause(a) and man | ner sa stated. | | | | | | |
| O. | one) 2 MEDICAL EXAMIN | ER: On the basis of examination | on and/or investigation, i | n my opinion, o | leath occured at the | time, data end placa, and | d due to the cause(| a) and manner as stated. | | | | | |
| H | 29b. SIGNATURE AND TITLE OF CERTIFIE | * MD | | | 29c. LICENSE NUI | WBER 2915 | 29d, DATE SIGNED | (Month (Day, Year) | | | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON W | O COMPLETEO CAUSE OF DE | EATN (ITEM 27) (Type, Pri | m) wA | SH X | d west | runst | in MBIID | | | | | |
| | 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE AUG 2 6 1994 July Day Land | | | | | | | | | | | | |

1 - FOR STATE REGISTRAR

| | _ | REGISTRAR | | CERTIF | ICATE C | OF DEATH | REG. N | O. | | | | |
|--|--------------|--|--|-------------------------|-----------------------------|--|--|----------------------------|--|--|--|--|
| • | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH MONTH | DAY YE | 3. TIME OF DEATH | | | |
| • | | SANDY C | LIFFORD COM | IBS | | | Aug. 24 | | 10:06 PM M | | | |
| .0 | 1 | 4. SOCIAL SECURITY NUMBER | 5. SEX 8. AGE | (In yrs. lest birthday) | IF UNDER 1 YEA | AR IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8.8 | IRTHPLACE (State or Foreign | | | |
| - LLL | | 215-05-2431 | 1 🔀 M 2 🗆 F 💮 | 3 YRS. | MONTHS DAY | YS HOURS MIN. | (Month, Day, Year) | | ountry) | | | |
| 1000 | V | 9a. FACILITY NAME (If not institution, give st | | .3 | 9h CITY TOV | WN OR LOCATION OF DE | July 1, | 1911 V | irqinia | | | |
| 促为国 | l a | | | | | | -AIN | | | | | |
| W-1 | 1 2 | 1521 Southview Rd | • | | <u> </u> | el Air | | Ha | rford | | | |
| - | RECTOR | 10s. STATE 10b. COUNTY | - | 10c, CIT | Y, TOWN OR LO | CATION | | - | 10d. INSIDE CITY | | | |
| 1 2 m | 18 | Maryland Har | fored | | | | | | LIMITS? | | | |
| 黄一 | | 10a, STREET AND NUMBER | ford | | Bel | | | 1 | 1 TES 2 NO | | | |
| e e | ERAL | | | | | 10f. ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? | | | |
| DZO physician. burial-transit | | 1521 Southview Rd | • | | | 21015 | | | USA | | | |
| 020 physician. burial-trar | FC | 11. MARITAL STATUS | 12. WAS DECEDENT EVER II FORCES? 1 YES | | | DECENDENT OF HISPAI , specify Cuben, Maxica | | as or No- 14. | RACE — American Indian, Black, White, atc. | | | |
| | BY | 1 Naver Married 2 X Married 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR D | | | YES 2 NO Specifi | | | Specify: | | | |
| Z15-0020 attending physic se as the burial | | 3 WHOMES 4 DIVORCES | | | | | | | White | | | |
| afte aste | ED | 15. DECEDENT'S EDUC (Specify only highest grade | | 16a. DECEDENT'S | USUAL OCCUP | ATION most of working | 16b. KIND OF E | USINESS/INOUST | RY | | | |
| lo ro | l iii | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT u | se retired.) | most or working | | | | | | |
| NOSpits ached | J d | 8 | 1440 | Pla | int Man | ager | | Chemia | cal | | | |
| the hospital or detached for u | COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Maid | en Sumame) | | | | |
| 8 E E | 111 | Sandy Marion C | ombs | | | Martha | Adeline | McCra | W | | | |
| should should | 00 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Str | et and Number or Rural | Bouta Number City or T | nun Stete 7in Cod | 1 | | | |
| > 2 2 2 | 2 | Nora L. Combs | | | | iew Rd., E | | | 1 | | | |
| | | 20a. METHOD OF DISPOSITION | | | | | | | | | | |
| LINORE, Page 6 may be ral director, page | | 1 2 Burial 2 Cremation 3 A floring | over from State Cen | PLACE AND DATE | OF DISPOSITION (ther place) | Name of | DATE 20c. I | OCATION City | | | | |
| Jeath, Page 6 m funeral director, | | 4 Donation S. Other (Specify) | 1,1/ / IB | el Air M | | 1 Gardens | | Bel Ai | r, Md. | | | |
| P. P. | | 21. SHEMATURE OF FUNERAL SERVICE LIS | 1119110, | | HOW | E AND ADDRESS OF FA | CILITY | Funeral | Home, P.A. | | | |
| | | 1/ Marak KI | 1111 | 1 | | | | | Md. 21009 | | | |
| S after c by the removal. | | 23. PART I. Enter the diseases, or c | omnifications that cause | the death Do | | | | | | | | |
| 5 4 9 | 1 1 | shock, or heart failure. I | List only one cause on e | ach line. | not onter the | A dying, suc | in all cardiac or rea | piratory arreat, | Approximate interval Between | | | |
| e on e | | IMMEDIATE CAUSE (Final disease or condition) | | | | | | | | | | |
| with pletely fille cremation, rent, the | | resulting in death) | | | | | | | | | | |
| | | DUE TO (OR AS A CONSEQUENCE, NF): | | | | | | | | | | |
| executed and corr to burial, matic ex | | Sequentially list conditions, | Co | recale | 10 H | earl 0 | allen | ' | | | | |
| UX 000 UV | ERTIFICATION | if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE O | F): | | | | | | | |
| ficate be physician ne prior t | 2 | CAUSE (Disease or injury | * | | | | | | | | | |
| n certifica nding phy Hygiene | 쁜 | that initiated eventa | DUE TO (OR AS A | CONSEQUENCE O | F): | | | | | | | |
| leath certii attending mai Hygier | H | resulting in death) LAST | 1 | | | | | | | | | |
| 0 0 0 5 | 0 | PART ii. Other aignificent condition. | a contribution to death b | us not requising | In the control | | D. 47 | | | | | |
| and the N | | TAIT II. Other algrinices Condition | e contributing to death b | ut not remulting | in the underi | ying cause given in | | ORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | | |
| 10 E E | ă | | | | | | 1 YES | 2 🗌 NO | OMPLETION OF CAUSE OF DEATH? | | | |
| . T " I P | × | | | | | | | | 1 TES 2 NO | | | |
| all Resident Dept. of 23 sho | ä | DID TOBACCO USE C | ONTRIBUTE TO | CAUSE OF | DEATH | YES NO | | 1 | | | | |
| | | 25. WAS CASE REFERRED TO MEDICAL | | | 20 | . PLACE OF DEATH (Ch | eck only one) | | | | | |
| SICIAN: The certificate to the State | S | EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outp | patient 3 DOA | OTHER: | Home 5 Residence | 9 Other (Specific) | | | | | |
| PHYSICIAN: this certifica with the St | | 27. MANNER OF DEATH | 28a, DATE OF INJURY | 26b. TIW | | INJURY AT | 28d. DESCRIBE HOV | / IN ITIES OCCURE | 0 | | | |
| NG PHYS feer this ceath with | ۵ | 1 Netural 5 Pending | (Month, Day, Year) | | JURY | WORK? | 200. DEGOTIOE 1101 | INDUNT OCCURE | | | | |
| DING After death | | 2 Accident Investigation | 20. 81 405 05 10 11 11 | | | | | | | | | |
| 2 6 2 5 | | 3 Suicide 8 Could not be 4 Homicide determined | 28a. PLACE OF INJURY building, etc. (Spec | cify) | etreat, factory, o | offica | 28f. LOCATION (Street City or Yown, Sta | et and Number or Ri te) | ural Route Number, | | | |
| A ATTE | 1 5 | | | | | | | | | | | |
| L DR A DIRECT DIRECT POURS | 1 4 1 | 29a. CERTIFIER (Check only | CIAN: To the best of my know | ledge, death occurr | ed at the time, | data and place, and due | to the ceuse(s) and m | anner es stated. | | | | |
| HOSPITAL FUNERAL within 72 h | O | | R: On the basis of examination | | | | | | use(s) and menner es stated. | | | |
| THE HOSP THE FUNE filed within | 8 | 296. SIGNATURE AND TITLE OR CERTIFIER | 0 11 | | | 29c. LICENSE NUI | | | | | | |
| 물 물을 없 | H | (1)/0 | le rall | | | TO I ST | イク | CA 2 | NED (Month, Day, Year) | | | |
| ₽₽≥₹ | 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF THE | ATM STEAM OF THE | Other | 10106 | 15 | 1-2/2 | >/74 | | | |
| | | VAD | COMPLETED CAUSE OF DE | - | 1 | ni. | / | 6.1 | | | | |
| | | Jaseph H. Kein | rardt 20 | 03 Koc | k Spri | ng Kd. | orest H | II MD | 21020 | | | |
| | 1 | 31. DATE FICED (Month, Day, Year) AUG 2 6 1994 | 32 AEGISTRAR'S SIGN | ATURED AND ALL | | , | | | | | | |
| | 1 1 | 1 100 NO 1334 | The state of the state of | in a did Colomb | | | | | I | | | |

FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| REGISTRAR | | CER | ITIFICA | TE OF | DEATH | | REG. NO. | | | | |
|--|-----------------------------|----------------------------------|--|----------------------------|--|------------------|------------------------------------|-------------------|---------------------------------|---------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF | DEATH | | 3. TIME OF DE | ATH | |
| FISIE | V. Ch | APMAY | 1 | | | MONTH | R MY | QZZ. | 8 | A. | |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 6 | . AGE (In yrs. last bir | thelms) IE III | IDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF | BIOTH CL | 1 2000 | HPLACE (State or | 5 | |
| | 1 - M 2 M F | | MONT | | HOURS MIN. | (Month, D | | Count | ry) | roreign | |
| 579 44 3731 | | 82 | YRS. | | 0.61 | July | 2 1912 | Mar | yland | | |
| 9a. FACILITY NAME (If not institution, give a | | | | | OR LOCATION OF | DEATH | | DUNTY OF | | | |
| Crofton Convales | scent Cent | er | 100 | Croft | on | | 1 | Anne A | Arundel | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE 10b. COUNT | Y | 10 | Oc. CITY, TOV | N OR LOCA | TION | | | | 10d. INSIDE CI | TY | |
| Maryland Anne | Arunde1 | | Crof | ton | | | | | 1 YES 2/ | NO NO | |
| 10e. STREET AND NUMBER | | | 0101 | | f. ZIP CODE | | 10g. C | ITIZEN OF | WHAT COUNTRY | 41 | |
| 2131 Davidsonvil | la Dand | | | | 0111/ | | | | | | |
| Crofton Convales RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT Maryland Anne 10c. STREET AND NUMBER 2131 Davidsonvil 11. MARITAL STATUS 1X Naver Merited 2 Maryland 1X Naver Merited | 12. WAS DECEDENT | EVED IN III O ADMITS | | 40 000 00 | 21114 | | | | States | | |
| | FORCES? 1 | YES 2 NO | ' | | CENDENT OF HISP/ Hecity Cuban, Maxk | | | - 14. RAC Blac | E American In k, White, etc. | idlan, | |
| 3 Widowed 4 Divorced | IF YES, GIVE WAF | OR DATES " N | lo | 1 TYES | NO Spec | | | Spec | | | |
| | <u> </u> | | | | | No | | | White | | |
| 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 3 rd 17. FATHER'S NAME (First, Middle, Last) | CATION completed) | 16a. DECED | SENT'S USUA kind of work do NOT use retire | L OCCUPATI one during m | ON ost of working | 16b. KII | ND OF BUSINESS/ | INDUSTRY | | | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | ille. Do | NOT use retire | (d.) | | 5 377 | | | | | |
| 3rd | | Н | lousek | eeper | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | 16. MOTHER'S N | AME (First, Midd | fle, Maiden Surname | 9) | | | |
| Frank S. Chapman | | | | | 1771 | | | | | | |
| Frank S. Chapman 190. INFORMANT'S NAME (Type/Print) | | T | | | | | n Chapma | | | | |
| The state of the s | | | | | and Number or Rura | | | | | | |
| Donald A. Chapmar | 1 | 5 | 04 An | ne St | reet F | 'alls c | hurch Va | a. 220 | 046 | | |
| 20a. METHOD OF DISPOSITION 12 Buriel 2 Cremetion 3 Rem | cumi from State | 20b. PLACE AND | DATE OF DIS | POSITION /N | | DATE | 20c. LOCATION | | | | |
| 4 Donation 6 Other (Specify) | OVER TROIT STATE | Green I | ory or other pie Hill | emete | rv | 1 | Berry | ville | Virgin | nia | |
| 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | | | ND ADDRESS OF F | ACILITY | | | | 11.0 | |
| Kolut & | 117111 | V. | | | | | | | | | |
| Journ C.C | -vurs | , Mes | 1. | 1600 | 0 Annapo | olis Rd | . Bowie | Md. | 20715 | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| resulting in death) LAST | | | | | | | | | | | |
| PART II. Other algnificant condition | a contributing to de | eath but not reau | ilting in the | underlyln | g cause given i | Part I. 24 | a. WAS AN AUTOPS | SY 248 | . WERE AUTOPSY | | |
| Cerebro voice | 7) | 4 4 | | | | | PERFORMED? | | AVAILABLE PRIC | | |
| Consister 1100 | L 00 | | | | | 1 | YES 2 MO | | OF DEATH? | | |
| Congelline Well | UT Tail | ire | | | | | | | 1 TYES 2 | ZHO | |
| | V | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSSITT | | | | LACE OF DEATH (C | heck only one) | | | | | |
| 1 YES 2 ATO | HOSPITAL: 1 Inpatient 2 I E | R/Outpetlent 3 🗆 | | IER: Nursing Hon | ne 6 🗆 Realdence | 6 Other /S | pecify) | | | | |
| 27. MANNER OF DEATH | 26a. DATE OF IN | JURY 20 | Bb. TIME OF | 28c. IN. | IURY AT | | IBE HOW INJURY | OCCURED | | | |
| 1 Netural 5 Pending | (Month, Day, | | INJURY | W | YES 2 NO | | | | | | |
| 2 Accident Investigation | 20- 04-05-55 | AL HUMAN | 4 | | | | | | | | |
| 3 Suicide 6 Could not be | building, et | NJURY — At home, c. (Specify) | farm, street, | factory, offic | • | 281. LOCATIO | ON (Street and Num lown, State) | ber or Rural | Route Number, | | |
| 4 Homicide determined | | | | | | | | | | | |
| 29a. CERTIFIER 1 CERTIFYING PHYSI | CIAN: To the best of m | v knowledne riesth | occurred of t | he time det | and place, and de | a to the course | a) and menner co | stated | | | |
| (Check only one) 2 MEDICAL EXAMINE | | | | | | | | | e) and marros | | |
| | | | -uganan, mil | ny opinion, i | occurred at th | - come, date and | w place, and due to | vine ceuse(| e, and menner at | ataned. | |
| 296, SIGNATURE AND TITLE OF CERTIFIE | and A | | | | 29c. LICENSE NI | JMBER | 29d. D | ATE SIGNED | (Mpnth, Day, Yes | ur) | |
| of com | (VIV) | | | | D 38 | 158 | • | 8/29 | 196i | | |
| 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE | OF DEATH (ITEM 27 | 7) (Type, Print) | | | * | | 1-1 | 1 1 | | |
| DALTEET SIM | 1611 811 | 1411 1 | 417 11 | MAIN A | m110 11 | MA H | INC OT | FAIT | | 17/11 | |
| | | | | | | | | | | | |
| 24 DATE EN ED MACHE STEEL STEEL | 10111 016 | | 113 111 | 4/4//7 | 160 /60 | 17.10 17 | 100 00 | 6141 | cry M | UMIL | |
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR | | 113 111 | V/V/F/7 |)LU /CI | 17 | 100 00 | 6141 | cry M | UMIL | |

BALTIMORE, MARYLAND 21215-0020

iours after death. Page 6 may be retained by the hospital or attending physician

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Fours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burnary be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

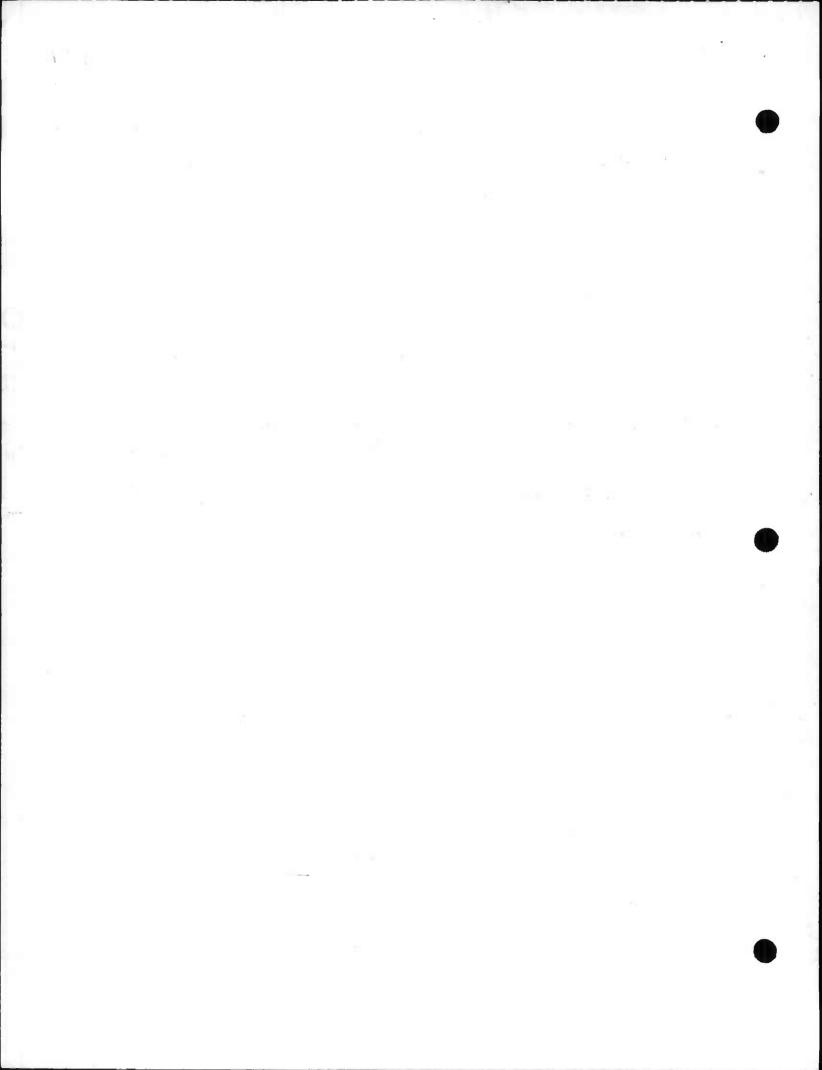
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit pe filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

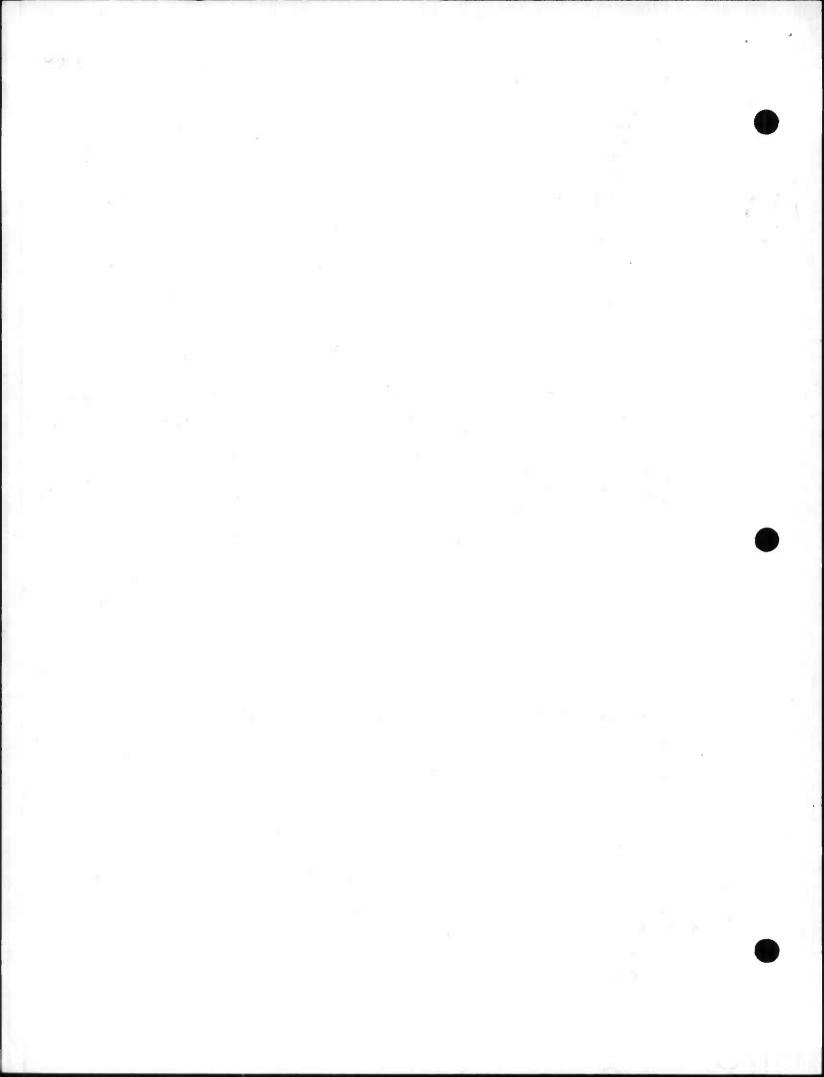
1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | REGISTRAR | | | | CERTIF | ICATE C | F DEATH | | REG. NO | | | | | |
|------------------|--|-----------------|--|------------------------------|-----------------|----------------------------------|--|----------------------|-------------------|---------------------|------------|---|--|--|
| ė | 1. DECEDENT'S NAME (First | , Middle, Last) | | | | | | | E OF OEATH | 157 | | 3. TIME OF DEATH | | |
| | | | | | | | | | | NTH DAY YEAR 1140 A | | | | |
| | 4. SOCIAL SECURITY NUM | | | 6. AGE (In yrs. | | IF UNDER 1 YE | AR IF UNDER 24 HRS | \rightarrow | E OF BIRTH | 0, 1- | | HPLACE (State or Foreign | | |
| - 6 | | | 1 (M 2 F | | 50.25 | MONTHS DA | | . (Mo | nth, Day, Year) | | Coun | try) | | |
| | 143-28-0725 | | | 56 | Tho. | | | | -16-37 | | Ne | w Jersey | | |
| _ | 9a. FACILITY NAME (If not in | | | | | 9b. CITY, TOY | VN OR LOCATION OF | DEATH | | 9c, COU | NTY OF | DEATH | | |
| 8 | Atlantic (| Genera. | l Hospita | 1 | | Ber] | in | | | Wo | orces | ster | | |
| 5 | RESIDENCE OF DEC | | | | | | | | | | | | | |
| Ë. | 10e. STATE | 10b. COUNT | | | | Y, TOWN OR LO | CATION | | | | | 10d. INSIDE CITY | | |
| ā | Md. | Word | cester | | E | Berlin | | | | | | LIMITS? | | |
| ၂ | 10e. STREET AND NUMBER | | | | | | 10f. ZIP CODE | | | 10a CIT | TEN OF | WHAT COUNTRY? | | |
| M | 2 Starbo | and Cou | unt | | | | 21811 | | | USA | | WHAT COUNTRY? | | |
| FUNERAL DIRECTOR | | 11 6 600 | | | | | 21011 | | | 00, | - | | | |
| ᆵ | 11. MARITAL STATUS | | 12. WAS DECEDENT FORCES? 1 | EVER IN U.S. | ARMEO | | DECENDENT OF HIS , specify Cuban, Mex | | | or No- | 14. RAC | E — American Indian, ck, White, atc. | | |
| ВУ | 1 Never Married 2 3 | | FORCES? 1 | R OR DATES | | | | ecify: | rican, etc.) | | Spec | offv: | | |
| | 3 Widowed 4 Dive | rced | | '5 | 7-163 | | | | | | | White | | |
| | | EOENT'S EDU | | 16e. | DECEOENT'S | USUAL OCCUP | ATION | 16 | b. KIND OF BU | SINESS/INI | DUSTRY | *** | | |
| ᇤ | Elementary/Secondary (I | | College (1-4 or 5+) | | life. Do NOT us | vork done during se retired.) | most of working | | | | | | | |
| ٦ ا | 12 | | College (1-4 b) 5+) | | Bldg. | Inspec | ctor | | Munici | palit | ty. | | | |
| COMPLETED | 17. FATHER'S NAME (First, N | iddle Lost | | | | - | | | | | - | | | |
| 8 | | | | | | | | | Middle, Malden | Surname) | | | | |
| H H | Francis M | | stel | | | - | | | Guerin | | | | | |
| | 19a. INFORMANT'S NAME (| ype/Print) | | | 19b. MAILING | ADDRESS (Str | et and Number or Rui | ral Route Nui | mber, City or Tow | n, Stete, Zij | o Code) | | | |
| 임 | Judy C. C | nriste | 1 | | | | ines Be | | | | | | | |
| - 1 | 20a. METHOD OF DISPOSIT | | | 00h DI 40 | | | | | | | | | | |
| - 1 | 1 🗆 Burial 2 🖟 Crematic | n 3 🗌 Rem | oval from Stata | cemetery, | crematory or o | of DISPOSITION ther place) | | DA | | CATION - | | | | |
| - 1 | 4 Donation 5 Other | | - 1 | Sal | isbury | / Crema | | | Sa | lisbu | ry, | Md. | | |
| - 1 | 21. SIGNATURE OF FURERA | L SERVICE LIC | ENSEE | | | 22. NAM | E AND ADDRESS OF | FACILITY | | | | | | |
| - 1 | D 4611.1 | 9 /11 | Mist | | | 11111 | rich Fune | ral H | lome B | erlir | a. M | d. | | |
| _ | TIMES | 1/11 | un C | | | | | | | | • | - | | |
| ı | 23. PARTY. Enter the d | seases, or o | complications that List only one caus | caused the | death. Do r | ot anter tha | moda of dylng, s | uch as ca | rdiac or reap | iratory an | rest, | Approximata | | |
| - 1 | IMMEDIATE CAUSE (Fir | | Clat Only Gas-caus | e on each ii | na. | ~1 | 7 | | | | | Onset and Death | | |
| | disease or condition | | | | | | | | | | | | | |
| | reaulting in death) | | | | | | | | | | | | | |
| | | | 221 | JA AS A CON | SECUENCE UI | 1- | Zich | | | 1 | 15 | | | |
| 중 | Sequentially list condit | lons. | ь | Lacs | v ec | 2/ 1 | つしん | ~ | _ | | - Marie | | | |
| Ĕ | If any, lasding to imme | diata | DUE TO (C | HAS A CONS | SECHENCE OF | 7: | | | | | | | | |
| 2 | cause, Entar UNDERLY CAUSE (Disease or Init | | a 24- | VC U | 1) | | | | - | | | | | |
| CERTIFICATION | that initiated events | | DUE TO (C | OR AS A CONS | RECHTENCE OF | n. | | | | | | | | |
| | resulting in death) LAS | T | d | | | | | | | | | | | |
| 뜅 | | | | | | | | | | | | - | | |
| ا بر | PART II. Other algolitica | nt condition | contributing to d | leath but no | t reaulting i | n tha undari | ying cause given | In Part I. | 24a. WAS AN | | 241 | . WERE AUTOPSY FINDINGS | | |
| <u></u> ≥ | | | | | | | | | PERFOR | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | |
| EDICAL | | | | | | | | | 1 TYES 2 | □ NO | | OF DEATH? | | |
| Σ | | | | | | | | | | | | 1 _ YES 2 _ NO | | |
| z I | DID TOBACCO U | SE CONTI | RIBUTE TO CAU | ISE OF DE | ATH YE | S NO | ☐ UNCERTA | AIN 🗆 | | | | | | |
| <u> </u> | 25. WAS CASE REFERRED T | MEDICAL | | 26. PL | ACE OF DEAT | H (Check only | ine) | | 16.5 | | | | | |
| PHYSICIAN: | EXAMINER? | | HOSPITAL: | ER/Outpatlant | 3 DOA | OTHER: | tome 5 ☐ Residenc | na 8 17 Aug | The Control of | | | | | |
| ` ∥ | 27, MANNER OF GEATH | | 26a. OATE OF II | | 28b. TIM | | INJURY AT | _ | | | OLIDEO. | | | |
| | - | Pending | (Month, Day | | | URY | WORK? | 200. DE | SCRIBE HOW I | NJUHT OC | COMEO | | | |
| ĕ | | Investigation | | | | | YES 2 NO | | _ | | | | | |
| 9 | 3 Suicide 6 | Could not be | 26e. PLACE OF building, et | INJURY - At Ic. (Specify) | home, ferm, s | treet, factory, | office | 26f. LO | CATION (Street I | and Number | r or Rural | Route Number, | | |
| ETE | 4 Homicide | datermined | | | | | | \ \frac{\sqrt{n}}{n} | , iomin, ordina) | | | | | |
| ب | 29a. CERTIFIER | TEVING BUYOU | CIAN: To the head of | na benevite de | death | 4 -4 45 - 11 | | 1778 | | | | | | |
| 矣။ | | | CIAN: To the best of m | | | | | | | | | | | |
| COMPL | 2 _ MEO | EXAMINE | m. On the basis of axa | mination and/ | or investigatio | n, in my opinio | n, death occured at t | the time, det | ta and place, an | d due to It | na cause(| s) and menner es atated. | | |
| w II | 296. SIGNATURE AND TITLE | OF CERTIFIER | + / | 10 | | | 29c, LICENSE N | NUMBER . | | 29d, DAT | E SIGNE | (Month, Day, Year) | | |
| ∞ ∥ | 1 | 1/ | 4 | 13 | | | - | | | • | | | | |
| ᄋᆘ | 30. NAME AND ADDRESS OF | pageon we | of continuous | DE DEATH | TEM OF T | David Control | | | | _ | | | | |
| - | THE PROPERTY OF | JESSON WH | COMPLETED CAUSE | OF DEATH () | EM 27) (Type, | Hadi | | | | | | | | |
| - 11 | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| , | 31. DATE FILEO (Month, Day. | | 32. REGISTRAR | | | | | | | | | | | |
| | 31. DATE FILEO (Month, Day, AUG 2 | | 1 | 'S SIGNATURE | | | | | | | | | | |



IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | | TMENT OF H | | MENTAL HYGIEN | | |
|------------------|---|---|---|--|-----------------------------|--|------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Lust) | | | | | 2. DATE OF OEATH | | 3. TIME OF DEATH |
| | William | Kent | | Larke, S | r. | July 29, | 1994 | 5:15 A M |
| | 220 42 1001 | 5. SEX 6. AGE (1 | in yrs. last birthday) YRS. | MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Morith, Day, Year) | Co | RTHPLACE (State or Foreign untry) |
| | 9a. FACILITY NAME (If not institution, give stre | H - 1. | 9 ms. | 9b. CITY, TOWN O | OR LOCATION OF DE | Nov 30, 1 | 944 M | aryland |
| e e | Naval Hospital | | | | ent Rive | | St. M | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN OR LOCAT | | | 1 00. 11 | 10d. INSIDE CITY |
| E | Maryland St. | Mary's | | xington | | | | LIMITS? 1 YES 2 NO |
| *AL | 10e. STREET AND NUMBER | | | 101 | . ZIP CODE | | | F WHAT COUNTRY? |
| FUNERAL | | Vay | 1110 400450 | 1 | 20653 | | U.S. | |
| | 1 Never Married 2 X Married | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR ON | 2X NO | II yes, sp | | IIC ORIGIN? (Specify Yes n, Puerto Rican, etc.) | В | ACE — American Indian, lack, White, etc. |
| B € | 3 Widowed 4 Divorced | | | | | | Wf | îî'te |
| | 15. DECEDENT'S EDUCA (Specify only highest grade of | ompleted) | 16a. DECEDENT'S (Give kind of life. Do NOT u. | WSUAL OCCUPATION Work done during mose retired.) | st of working | 16b. KIND OF BUS | SINESS/INDUSTR | Y |
| COMPLETED | Einmentary/Secondery (0-12) 12th Grade | College (1-4 or 5+) | | , (| wner/ echnician | vendir | ng Machi | ne Company |
| S | 17. FATHER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S NA | ME (First, Middle, Maiden | | |
| BE | William Er 190. INFORMANT'S NAME (Type/Print) | mest | Clark | | Rosal | | enwell | Guy |
| 2 | Norma Marie Clarke | 2 | | | | Poute Number, City or Tow | | ryland 20653 |
| | 20a. METHOO OF OISPOSITION 11∑Burial 2 ☐ Cremation 3 ☐ Remove | 20b. | PLACE AND OATE | OF DISPOSITION (Na | me of | | CATION — City o | |
| | 4 Donation 5 Other (Specify) | S | t. John | s Cemete | | | lywood | Maryland |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | L 1. | , | Mattin | d aboress of FA | diner Fune | ral Hom | e, P.A. |
| - | 11 uchaels | prdiner |) | | | | | land 20650 |
| | 23. PART I. Inter the diseases, or co | ist only one cause on e | sch line. | not enter the mo | de of dying, suci | h as cerdiec or respi | retory errest, | Approximate Interval Between |
| | IMMEDIATE CAUSE (Finel disease or condition reaulting in deeth) | MYDO | ARdi | ALT | WI-AR | cTION | | Onsst and Death |
| | a. | DUE TO TOR AS A | CONSEQUENCE O | F): | V | | | |
| NO | Sequentielly list conditions, b. | DUE TO (OR AS A | CONSEQUENCE O | D. | | | | |
| CATI | If sny, leading to immediate cause. Enter UNDERLYING | 002 10 (011 710 7 | CONSCORENCE O | •). | | | | İ |
| CERTIFICATION | CAUSE (Disease or Injury that Initiated events reaulting in deeth) LAST | DUE TO (OR AS A | CONSEQUENCE O | F): | | | | |
| CER | d. | | | | | | | |
| A. | PART II. Other significent conditions | contributing to deeth b | ut not resulting | In the underlyin | g ceuse given in | Part I. 24s. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| 00 | | | | | | 1 YES 2 | ™ NO | COMPLETION OF CAUSE OF GEATH? |
| Σ. | DID TOBACCO USE CO | ONTRIBUTE TO | CAUSE OF | DEATH Y | ES NO | 1 | | 1 TYES 2 NO |
| IAN | 25. WAS CASE REFERRED TO MEDICAL | | C/1002 01 | | ACE OF DEATH (Ch | | 1 | |
| PHYSICIAN: MEDIC | YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outp | atient 3 DOA | OTHER: 4 Nursing Horn | e 5 🗆 Rasidence | 6 Other (Specify) | | |
| | 27. MANNER OF DEATH 1 Natural 5 Pending | 26s. DATE OF INJURY (Month, Day, Year) | 28b. TIM | JURY WO | RK? | 26d. DEŞCRIBE HOW I | NJURY OCCURED | |
| 8√ | Accident Investigation 3 Suicide a Could not be | 26s. PLACE OF INJURY | — At home, lerm, | | rES 2 NO | 2af. LOCATION (Street a | and Number or Ru | ral Route Number, |
| COMPLETED | 4 Homicide datarmined | building, etc. (Spec | iny) | | | City or Town, State) | | |
| PLE | | IAN: To the best of my knowl | | | | | | |
| SON | | On the basis of examination | and/or Investigation | on, in my opinion, d | eath occured at the | time, data and place, an | d due to the cau | se(e) and menner ee stated. |
| BE | 296. SIGNATURE AND TITLE OF OCHTIFIER | X=1 | | | 29c. LICENSE NUN | | 110-1-1 | IEO (Month, Day, Year) |
| 임 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETEO CAUSE OF OE | ATH (ITEM 27) (Type | , Print) | 017 | 285 | 1 | -29-14, |
| | William D. Boyd. | II. M.D. | | | dtown, Ma | aryland 2 | 0650 | |
| Ì | 31. DATE FILEO (Month, Day, Year) | 32. BEGISTRAR'S SIGN. | ATURB Hardall | | | | | |
| | AUG 01 1994 | Jane Wood | | | | | | DHMH. 16 9au 1/90 |



FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| REGISTRAR | | | | ERTIFIC | CATE | F DEATH | R | EG. NO. | | | |
|--|-------------------------|---------------------------|---------------------------------|-------------------|------------------|--|----------------------------|----------------------------|-----------|--------------------|---|
| 1. DECEOENT'S NAME (First | 177-200 | | | | | | 2. DATE OF I | D. A1 | v | YEAR | 3. TIME OF DEATH |
| Shirley Co | | | | | | | July | 27, 🖺 | 1994 | IEAN | 11:00A. M |
| 4. SOCIAL SECURITY NUM | BER | 5. SEX | 6. AGE (In yrs. le | | IF UNDER 1 YEA | | 7. DATE OF E (Month, De | | | 8. BIRTH Countr | IPLACE (State or Foreign |
| 232-36-519 | 0 | 1 🗙 M 2 🗌 F | 83 | YRS. | ONTHS DAY | B HOURS MIN. | Februa | ry 22 | ,191 | 1 W | |
| 9e. FACILITY NAME (If not in | nstitution, give s | treet and number) | | | 9b. CITY, TOV | N OR LOCATION OF E | DEATH | | 9c. COUR | NTY OF D | EATN |
| St. Mary's | | ng Cente | r | | Leo | nardtown | | | St | . Ma: | ry's |
| 10e. STATE | 10b. COUNTY | 1 | | 10c. CITY. | TOWN OR LO | CATION | | | | | 10d. INSIDE CITY |
| Maryland | C+ . | Marry t a | | | | n Park | | | | | LIMITS? |
| 100. STREET AND NUMBER | St. | riary s | | Lex | TIIRCO | 10f. ZIP CODE | | | 10. OIT | TEN OF Y | WHAT COUNTRY? |
| 200 Lexwoo | d Driv | e. 7-B | | | | 20653 | | | | | States |
| 11. MARITAL STATUS | u DLIV | 12. WAS DECEDEN | | | 13. WAS | DECENDENT OF NISPA | NIC ORIGIN? (S | pecify Yee | | | |
| 1 Never Merried 2 🔀 | | FORCES? 1 | X YES 2 AR OR DATES | NO | It yee | specify Cuban, Mexic res 2 10 NO Spec | en, Puerto Ricar | | | Black Speci | E — American Indien, k, Whita, etc. |
| 3 Widowed 4 Divo | orced | WWI | | | | - LO 2 2 110 Open | ny. | | | Whit | |
| 15. DEC | EDENT'S EDU | CATION completed) | 18e. Di | ECEDENT'S U | SUAL OCCUP | ATION most of working | 16b. KIN | ID OF BUS | INESS/IND | | |
| Elementary/Secondary (I | 1 | College (1-4 or 5 | 1160 | Do NOT usa | retired.) | most or working | | | | | |
| 9 | | | Op | erato | r | | D | efen | se | | |
| 17. FATHER'S NAME (First, M | | | | | | 18. MOTNER'S N | | e, Maiden S | Surname) | | |
| Jay Farrel | | | | | | Debbie | | | | | |
| 190. INFORMANT'S NAME (| | | | | | et end Number or Rura | | | | | |
| Ruth J. Co. | gar | | 2 | 00 Lex | wood | Drive,7-B | , Lexin | igton | Par | k, M | D 20653 |
| 20s. METHOD OF DISPOSIT 1 X Burlel 2 Crematic | | oval from Stata | cemetery, cri | ematory or other | DISPOSITION | | OATE | 20c. LOC | ATION — | City or To | wn, State |
| 4 Donation 6 Other | | | Char] | les me | moria. | | 7/30 | Leo | nardt | town | ,Maryland |
| 21. highwayfie of runers | DINTO | Nest. | > | | | AND ADORESS OF F | | Home | | | |
| Michae | I K R | lankensh | in | | | | | | ım Ma | arwl. | and 20650 |
| 23. PART I. Enter the d | Iseeses, or o | omplications the | t caused the d | eeth. Do no | t enter the | mode of dying, su | ch as cardiec | or respir | atory arr | rest. | Approximate |
| shock, or h | aert fallure. | List only one tau | ea on eech lin | a. | | | | SH WAY | | | Interval Batwean |
| IMMEDIATE CAUSE (Find disease or condition | nel | 1 | t p | 1 | ngn | | | | | | Onset and Death |
| resulting in death) | | DUE TO | (OR AS A CONSE | | | | | | | | |
| | | | | | | | | | | | İ |
| Sequentielly list condit if any, leeding to imme | | DUE TO | (OR AS A CONSE | OUENCE OF): | ; | | | | | | |
| cause. Enter UNDERLY | ING | c. | | | | | | | | | |
| CAUSE (Disesse or Injuther Initiated events | | DUE TO | (OR AS A CONSE | OUENCE OF): | : | | | | | | |
| resulting in daeth) LAS | T . | d | | | | | | | | | |
| PART II. Other eignifica | nt condition | o contribution to | death bis ask | | NI CONTRACTOR | | 5 T | | 1011 | | |
| Ca a | and condition | s contributing to | deeth but not | rasulting in | tha Under | ying ceuse given li | 1 Part I. 24a | PERFORI | | 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| 2500 | 2 | - CC | 900 | ~~~ | _ | | 1 | YES 2 | KNO | | COMPLETION OF CAUSE OF OEATH? |
| Agree | eirs | 200 | | | | | | | | | 1 TYES 2 NO |
| - | | ONTRIBUTE | TO CAU | SE OF | DEATH | YES NO | | | | | |
| 25. WAS CASE REFERRED T EXAMINER? | O MEOICAL | HOSPITAL: | | | OTHER: | PLACE OF OEATN (C | heck only one) | | | | |
| 1 YES 2 VING | | 1 Inpatient 2 | | 3 🗆 DOA | Nursing I | lome 5 - Reeldence | 6 ☐ Other (Sp | ecify) | | | |
| 27. MANNER OF DEATH | Pending | 28e. DATE OF (Month, D | | 28b. TIME INJU | RY | INJURY AT WORK? | 28d. OESCRIE | BE HOW IN | JURY OCC | CURED | |
| Accident | investigation | | | | | YES 2 NO | | | | | |
| 3 Suicide 8 4 Homicide | Could not be determined | 28e. PLACE C building, | F INJURY — At he atc. (Specify) | ome, farm, str | reet, factory, o | ffice | 28t. LOCATIO City or To | N (Street ei wn, State) | nd Number | or Rural F | loute Number, |
| 20. CEPTIFIED 4 | | | | | _ | | | | | | |
| | | | | | | lata and place, end du | | | | | |
| 2 MEO | ICAL EXAMINE | R: On the basis of e | xamination and/or | Investigation | , in my opinio | n, death occured at th | e time, date end | place, end | due to th | e ceuse(e | e) end menner ee stated. |
| 29b. SIGNATURE AND TITLE | OF CERTIFIE | 11/ | 5 | | - | 29c. LICENSE NO | JMBER | T | 29d. DATI | E SIGNED | (Month, Day, Year) |
| | | 1 | | | | 10/9 | 7917 | | ▶ . | 7/2 | 2/94 |
| 30. NAME AND ADDRESS | PERSONAR | D COMPLETED CAU | SE OF OEATN (ITE | M 27) (Type, F | Print) | | | | | / | 4. |
| The second secon | oyd, M | .D. 13 | Jeffers | on Str | eet, | Leonardto | wn, Mar | ylan | d 20 | 650 | |
| 31. OATE FILEO (Month, | 0 1004 | 32. REGISTRA | R'S SIGNATURE | of all | | | | | | | |
| AUG 0 | 2 1994 | HEUN OU | WANTE MEDICAL | C July | | | | | | | |

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with ours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-16 Rev 1/89

. 1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | , | 1. DECEDENT'S NAME (First, Middle, Last) Mary Ethel Connelly 2. Date of Death Month Day YEAR August 6, 1994 | | | | | | | | | | | | 3. TIME OF DEATH | |
|---|---------------|--|--|---------------------------|------------------------|--------------|-----------------------|-----------|---|--|--------------|-----------------------|--------------|----------------------------------|---|
| | ŀ | Mary 4. SOCIAL SECURITY NUMBER | | Ethel Is. sex | 8. AGE (In yrs. I | | | | | | - | ıst 6, | 1994 | | 9:16 Pm |
| | | | | 1 M 2 V F | | YRS. | IF UNDER | DAYS | | | (Month | Dev. Year) 4, 191 | | Country | PLACE (State or Foreign |
| 9 | | 218-80-8286 | | 43 | 78 | THS. | | | | | | 4, 191 | | | yland |
| 3 should | <u> </u> | St. Mary's | | | | | | | OR LOCATION | | EATH | | 9c. COUN | | |
| mar of | | St. Mary's Hospital Leonardtown St. Mary's | | | | | | | | | | | | .у з | |
| | DIRECTOR | 10e. STATE | 10b. COUNT | Y | | 10c. Cl | TY, TOWN | R LOCA | TION | | | | | | 10d. INSIDE CITY LIMITS? |
| The second second | - 15 | Maryland | St. | Mary's | | L | eonai | rdto | nwo | | | | | 201 | 1 YES 25 NO |
| | 4 | 10e. STREET AND NUMBER | | | | | | 10 | f. ZIP COD | | PER. | | | | HAT COUNTRY? |
| | <u> </u> | P.O. Box 11 | .44 | | | | | | 2065 | 0 | | 3 3 | U. | S.A. | |
| 0 2 4 | BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divo | NT EVER IN U.S. A 1 YES 2 X WAR OR DATES | NO | | I1 yes, sp | CENDENT Copecify Cube | n, Maxica | NIC ORIGIN en, Puerto R fy: | - American Indian, , White, atc. y: Lte | | | | | |
| 15. | - 11 | 15. DEC | EDENT'S EDU | CATION | 16a, C | ECEDENT'S | USUAL O | CCUPATI | ON | | 16b. | KIND OF BUS | INFSS/INDI | | |
| 2121 al or after for use | COMPLETED | (Specify only Elementary/Secondary (0 | highest grade | College (1-4 or 5 | | Give kind of | work done | during m | ost of working | ng | 100. | THE OF BOO | ALCO OF ALCO | 701111 | |
| | 로 [| 11th Grade | 12, | Conege (I-4 or 5 | | Homem | aker | | | | 05 | Hom | e | | |
| YLAND by the hospit be detached at once. | 5 | 17. FATHER'S NAME (First, M | iddle, Last) | | | | | | 18. MOTHER'S NAME (First, Middle, Malden Surname) | | | | | 100100 | |
| ≥ 5 5 € I | u l | Robert | Wo | odley | Gode | dard | | | | | rine | | Maria | h | Coats |
| E 8 8 20 | 00 | 19a. INFORMANT'S NAME (7 | | -4 | | _ | G ADDRESS | S (Street | | | | er, City or Town | | | |
| | 2 | John P. Cor | nelly | , Jr. | | | | | | | | | | | 20650 |
| BALTIMORE, ter death. Page 6 may be the funeral director, page val. | | 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c, LOCATION — City or Town, State | | | | | | | | | | | | | |
| TORE e 6 may ector, pag | | 20s. METHOD OF DISPOSITION 1 XBurlai 2 Cremation 3 Removat from State 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, crematory or other piace) St. Pauls Un. Meth. Cemetery 8/10/94 Leonardtown, | | | | | | | | | | | | | |
| BALTIMORE, sr death. Page 6 may be tuneral director, pagnal. | | 21. SIGNATURE OF FUNERA | L SERVICE LI | CENSEE, | | rauls | 22. | NAME A | ND ADDRE | SS OF FA | CILITY | | | | |
| uner uner | | Mattingley-Gardiner Funeral Home, P.A. | | | | | | | | | | | | | |
| BA rs after do n by the fremoval. | _ | 01 picha | eeg | Han | ouner | | | | | | | | | | and 20650 |
| tely filed in the mation, or rei | • | | | | | | | | | | | | | interval Between Onset and Death | |
| o.O. BOX 68 | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | inknow | | |
| S, F he death the atter Mental Mental | 5 | | | 0. | | | | | | | | | | | |
| H = 70 - 1 | A I | PART ii. Other aignifica | nt condition | ns contributing to | deeth but not | reculting | in the ur | nderlyin | g cause | given in | Pert i. | 24a. WAS AN PERFOR | | 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| RECOR requires that seen signed by of Health an shows any | MEDICAL | | | | | | | | | | | 1 YES 2 | NO | COMPLETION OF CAUSE OF DEATH? | |
| EC quires outres (Heal | E I | | | | | | | | | | 1 TYES 2 NO | | | | |
| > 0 | AN | | | | | | | | M | | | | | | |
| VITAL AN: The law tificate has t e State Dept or Nem 23 | <u> </u> | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | | | | | | LACE OF D | EATH (C) | heck only on | •) | | | |
| VIAN: CIAN: britifical br Sta | SIC | 1 TYES 2 10 NO | | HOSPITAL: | ER/Outpatient | 3 🗆 DOA | 4 Nur | | ne 5 🗆 Re | sidenca | 6 🗆 Other | (Specify) | | | |
| 이 분 함 하 | ž | | Pending | 28e. DATE Of (Month, i | F INJURY Day, Year) | 28b. TII | ME OF JURY | W | JURY AT ORK? YES 2 | T MO | 28d. DE\$ | CRIBE HOW II | NJURY OCC | URED | |
| ONG DING After death | 2 | 2 Outsteam | Investigation | 26a. PLACE | OF INJURY — At | home, farm | street len | | | | 281 1.00 | ATION (Street a | and Mumber | v Rumi O | inustra Alisandras |
| S te EN | 3 | _ " " | Could not be determined | building | , atc. (Specify) | , ш, | acreet, inc. | ory, onn | | | City o | or Town, State) | na Number (| or Murair M | oure Number, |
| OR A DIRECT HOURS | <u> </u> | 29a. CERTIFIER 1 CERT | - | | | | | - | | _ | | | | | |
| | COMPLE | onel | | ICIAN: To the best of | | | | | | | | | | | and manner as stated. |
| Poer I | H D | 296. SIGNATURE AND TITLE | OF CERTIFIE | P | | | | | 29c. LICI | ENSE NU | MBER | | 29d. DATE | SIGNED | (Month, Day, Year) |
| 2 2 2 X | 2 ∦ | 30. NAME AND ADDRESS OF | PERSON WI | O COMPLETED CAL | JSE OF DEATH #1 | EM 27) (7vn | e. Print) | , , | 7 | 2/ | 068 | | , 0 | 1/1 | , , |
| | | DLSch | ewor | 2 /57 | Man | pr 1 | 100/- | Sis | Si | ouh | gene | y Der | + LE | ena | wdforan M |
| | | AUG | 9 199 | 32. REGISTR | of hurchest | Randal | | | - 6 | / | | | | | |

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BALTIMORE, MARYLAND 212

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| hours after death. Page 6 | lirect | |
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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a ho | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral directs | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal. |
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| _ | REGISTRAR | | CERTIF | ICATE O | PUEATH | REG. NO. | | | |
|---------------|--|--|------------------------------|----------------------------------|------------------------|--|-----------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Las | 1) | | | | 2. DATE OF DEATH | ve T | 3. TIME OF DEATH | |
| | therenan | Co | DEM 0 = | - | | MONTH D | "a d | 2 1050 " | |
| | 4. SOCIAL SECURITY NUMBER | <u> </u> | TAGE | - | | -0 a | 0 | | |
| | | The second secon | (In yrs. lest birthday) | MONTHS DAYS | | 7. DATE OF BIRTH (Month, Day, Year) | 6. | BIRTHPLACE (State or Foreign Country) | |
| | 213-22-8447 | 1 🕅 M 2 □ F 6 | 9 YRS. | WONTES DATE | HOURS WIN. | DEC. 25,1 | 924 I | DELÁWARE | |
| | 9s. FACILITY NAME (If not institution, give | e street and number) | | 9b. CITY, TOW | OR LOCATION OF D | | | Y OF DEATH | |
| æ | DORCHESTER GENER | | | | | | | | |
| ΙŌΙ | to the contract of the contrac | AL HOSTITAL | | CAMBRI | DGE | | DOKCE | HESTER | |
| 5 | RESIDENCE OF DECEDENT 10a. STATE 10b. COU | | | | | | | | |
| DIRECTOR | | | 10c. CIT | Y, TOWN OR LO | CATION | | 10d. INSIDE CITY LIMITS? | | |
| ā | MARYLAND DORC | | 1 X YES 2 NO | | | | | | |
| 7 | 10e. STREET AND NUMBER | | | | 10f. ZIP COOE | | N OF WHAT COUNTRY? | | |
| FUNERAL | 102 TEMPLE STREE | т | 21664 | 7.6 | | | | | |
| 뿔 | | | | | | | US | | |
| 교 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER FORCES? 1 7 YES | IN U.S. ARMED | 13. WAS D | ECENDENT OF HISPAI | NIC ORIGIN? (Specify Yes | or No 14 | RACE — American Indian, Black, White, atc. | |
| BY | IF YES GIVE WAR OR DATES | | | | | | | | |
| | 3 Widowed 4 Divorced | | | | | | - 1 | WHITE | |
| ᇜ | 15. DECEDENT'S E | DUCATION | 16a. DECEDENT'S | USUAL OCCUPA | TION | 16b. KIND OF BUS | SINESS/INOUS | STRY | |
| I I I | (Specify only highest gri | | (Give kind of life. Do NOT u | work done during se retired.) | most of working | | | | |
| ايرا | 5 | College (1-4 or 5 +) | FORKLIF | | | MANUFA | CTURIN | NG . | |
| Σ | | | | | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S NA | ME (First, Middle, Maiden | Surname) | | |
| BE (| EUGENE COPPAGE | | | | RICHA | McBRIDE | | | |
| | 19a, INFORMANT'S NAME (Type/Print) | | 19b, MAILING | ADDRESS (Street | | Route Number, City or Town | n. Stein. Zio Co | ode) | |
| 임 | PATRICIA COPPAGE | | the second second second | | | RETARY, MD | | | |
| | | | | | | | | | |
| | 20a. METHOO OF DISPOSITION 1 X Burlai 2 Cremation 3 R | | b. PLACE AND DATE | | | | | ly or Town, State | |
| - 1 | 4 Donation 5 Other (Specify) | | AST "NEW" | MARKET | CEMETERY | 8/24 EAS' | T NEW | MARKET, MD | |
| | 21. SIGNATURE OF PUMERAL SERVICE | LICENSEE / | 11 | 22. NAME | ANO AOORESS OF FA | CILITY 1.0 | 6 MATN | CTREET | |
| 1 1 | * | 1 8 1500 | /// | ZELL | ER FUNERA | L HOME, P. | O. BO | x 207. | |
| | / scrioux | - hy | 2 | EAST | NEW MARK | FT MD 21 | 631 | | |
| | 23. PART I Enler the diseases, o | r complications that cause | ed the death. Do | not enter the r | node of dying, auc | h as cerdisc or respi | relory arrea | it, Approximate | |
| | | e. List only one ceuse on | eech line. | | | | | intervei Between Onset and Death | |
| | iMMEDIATE CAUSE (Fine) | | • | | | | | | |
| | resulting in death) | . Theun | | | | | | 40 | |
| 1 | | | A CONSEQUENCE O | • | | | | 4d 4wo 18mo | |
| z | | b. Lough DUE TO (OR AS | 6+03K | Ses | | | | 4 ULO | |
| 은 | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS | A CONSEQUENCE O | PF): | | | | | |
| [X | ceuse. Enter UNDERLYING | Colon | CARNE | -63 | | | | 18410 | |
| ᇤ | CAUSE (Disease or injury that initiated events | DUE TO (OR AS | A CONSEQUENCE O | F): | | | | | |
| IĘ∣ | resulting in desth) LAST | | | | | | | | |
| CERTIFICATION | • | d | | | | | | | |
| | PART ii. Other eignificent condit | one contributing to deeth | but not regulting | in the underly | ing cause given in | Part i. 24s. WAS AN | AUTOPSV | 24b. WERE AUTOPSY FINDINGS | |
| EDICAL | | | | | | PERFOR | | AMILABLE PRIOR TO | |
| ă | LIVER Meta | STEDIO . | BONG Y | retosi | 2005 | 1 YES 2 | NO | COMPLETION DF CAUSE OF DEATH? | |
| 뿔 | | | | | | | | 1 TYES 2 NO | |
| | DID TOBACCO USE | CONTRIBUTE TO | CAUSE OF | F DEATH | YES I NO | | | | |
| SICIAN | 25. WAS CASE REFERRED TO MEDICAL | - CONTINUED TO | CAUGE OF | | PLACE OF DEATH (Ch | | | | |
| <u> </u> | EXAMINER? | HOSPHAL: | - | OTHER: | | | | | |
| \ ×S | 1 TYES 2 THO | 1 hpatient 2 ER/Ou | A. H. Comp. | | ome 5 - Realdence | | | | |
| РНУ | 27. MANNER OF DEATH | 26a. DATE OF INJURY (Month, Day, Year) | | | NJURY AT WORK? | 28d. DESCRIBE HOW I | NJURY OCCUI | RED | |
| ВУ | 1 Natural 5 Pending 2 Accident Investigation | n | | M 1 | YES 2 NO | | | | |
| | 3 Suicida 6 Could not | 26s. PLACE OF INJUR | | streat, factory, of | fics | 26f. LOCATION (Street a | | Rural Route Number, | |
| 요 | 4 Homicide delermined | | ecffy) | | | City or Town, State) | | | |
| COMPLETE | | | | | | | | | |
| ۵. | | YSICIAN: To the best of my kno | wledge, desth occur | red at the time, d | ets and place, and due | to the cause(s) and mar | nner sa stated, | | |
| 8 | 2 MEDICAL EXAM | INER: On the basis of axaminati | on end/or investigation | on, in my opinion | , death occured at the | time, data and place, an | d due to the o | cause(s) and manner as stated. | |
| | 296. SIGNATURE AND TITLE OF CERTIF | | | | T no. 1 transfer but | | | | |
| BE | 100 | 200 | 120 | | 29c. LICENSE NUI | MBER | 29d. DATE 5 | SIGNED (Month, Day, Year) | |
| 0 | (Mellall | alderse | - | | 4356 | 22 | 2- | 22-94 | |
| H- | 30. NAME AND ADDRESS OF PERSON | AND COMPLETED CAUSE OF D | EATH (ITEM 27) (Type | s. Print) | . 0 | | | 71-511 | |
| | CRAIGWUK | LACETTI | 2AUX | 30 E 0 | 5+ (in | 120,002 | - 41 | DZ1612 | |
| | 31. DATE FILED (Month, Day, Year) | 32 REGISTRAR'S SIG | NATURE | | 1 0 100 | The Contract of the Contract o | 1 | -10/4 | |
| | AUG 2 5 199 | | or Nardall | | | | | | |
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BALTIMORE, MARYLAND 21215-0020

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B.K.S 94 26182 ITEMS: 23 PART I, II, 27, 28a, b, c, d, e, f PER MEO G-715 9/9/94 reb FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF OEATN 3. TIME OF DEATH AUG. 94 OLIVER CAMPHER JR. 4:00 AM 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTN 8. BIRTNPLACE (State or Foreign DAYS HOURS 1 M 2 | F YRS. 215-78-6886 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 202 NORTH JONATHAN STREET HAGERSTOWN WASHINGTON RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland
100. STREET AND NUMBER Washington Hagerstown 1 YES 2 NO 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 202 North Jonathan Street 21740 U.S.A 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—It yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 11 MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 3 Wildowed 4 Divorced Specify: 04/19/77-05/05/80 Black 16a. DECEDENT'S USUAL OCCUPATION
The blad of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Spe (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (t-4 or 5 +) 11+h Maintenance Industrial \mathbf{E} 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Lelia Estelle Lewis-Campher Oliver Ishmael Campher 19a. INFORMANT'S NAME (Type/Print) 19b, MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oliver I. Campher 39 Charles St. Hagerstown, MD. 21740 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 20e. METHOD OF DISPOSITION

t Burlet 2 Cremation 3 Ramoval from State

4 Donetion 5 Other (Specify) Rose Hill 26 August | 1994 Hagerstown, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Watson F.H stl. 24 W. Bethel St. Hagerstown, MD, 21740 23. PART I. Entar tha diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or haart failure. List only one cause on each line. intarval Batween **IMMEDIATE CAUSE (Final** Onset and Death disease Dr condition NARCOTIC INTOXICATION resulting in death) DUE TO (OR AS A CONSEQUENCE OF) Sequantially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? END STAGE RENAL DISEASE t YES 2 | NO YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL OTHER: XXYES 2 NO Inpetiant 2 ER/Outpetiant 3 DOA 4 ☐ Nursing Nome XXRasidence 8 ☐ Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATN 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE NOW INJURY OCCURED 1 Natural FOUND 8/22/94 UNKNOWN** t YES 2 X NO

CERTIFICATION MEDICAL PHYSICIAN: BY ETED.

2 Accident

3 Suicide

4 Nomicide

281. LOCATION (Street and Number of Rural Route Number, City or Town, State) 2 0 2 N. JONA HAN ST.

HAGERSTOWN.

29a. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and menner as attend. (Check only one)

28a. PLACE OF INJURY — At home, term, straet, factory, office building, atc. (Specify)
FOUND AT HOME

2 XXMEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year)
AUG. 23, 1994 29c. LICENSE NUMBER

O.C.M.E

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

FOWLER 111 Penn Street, Baltimore, Maryland 21201 31. DATE FILED (Movith, Day, Year

AUG 2 6 1994

investigation

determined

8 XXCould not be

32. REMINITION S SIGNATURE in Dendom Ra

n and completely filled in by to bunal, cremation, or remo traumatic event, the attending physician I Mental Hygiene prior to other t ō signed by the shows a has been s Dept. of H 23 DIRECTOR: After this certificate hours after death with the State ò marked, 69

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TO THE FUNERAL D be filed within 72 h IMPORTANT: It It

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

DR ATTENDING PHYSICIAN: The law

HOSPITAL

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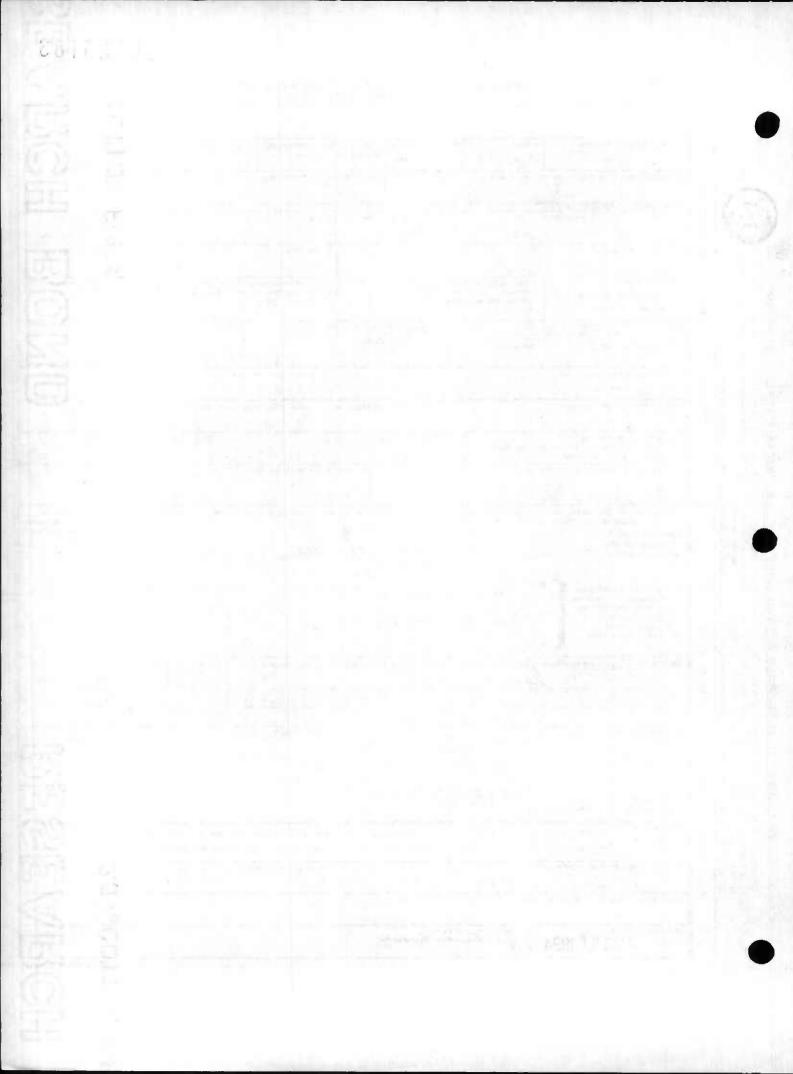
| BALTIMORE, MARYLAND 21215-0020 | ours after death. Page 6 may be retained by the hospital or attending physician. | r filled in by the funeral director, page 5 should be detached for use as the burial-transit tion, or removal. |
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| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Jours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit abe filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | HEGISTHAH | | | | EKIIL | ICAL | CP | DEA | I IT | REG. I | 10. | | |
|------------------|---|----------------------------|---------------------------|-----------------------------------|-----------------------------|-------------------|-------------------------------|-----------|----------|---|------------------|---|---|
| | 1. DECEDENT'S NAME (First, | Middle, Last) | | | | | | | | 2. DATE OF DEATH | DAY | YEAR | 3. TIME OF DEATH |
| | JOSEPHINE | EDI | TH | CARLSON | 1 | | | | | August 2 | | | 12:30 P. M |
| | 4. SOCIAL SECURITY NUMB | ER | 5. SEX | 6. AGE (In yrs. le | st birthday) | IF UNDER | | IF UNDER | | 7. DATE OF BIRTH (Month, Day, Year | | | PLACE (State or Foreign |
| - 4 | 173-03-3372 | | 1 M 2 X F | 86 | 6 YRS. | MONTHS | DAYS | HOURS | MIN. | January | | | |
| | 94. FACILITY NAME (If not ins | stitution, give s | street and number) | | | 9b. CITY | TOWN (| R LOCATI | ON OF D | | | UNTY OF DE | |
| 9 B | Coffm | an Nu | rsing Hor | ne | | Hag | erst | OWD | | | Was | shingt | on |
| 5 | RESIDENCE OF DEC | EDENT 10b. COUNT | | | | | | | | | Tirak | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | |
| E | | | ngton | | | Y, TOWH C | | ION | | | 10d. IN | | |
| 0 | Maryland | gerstown | | | | | 1 🕅 YES 2 | | | | | | |
| FUNERAL DIRECTOR | | 101. ZIP CODE 21740 | | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | | | | |
| 필 | 12 South Wa | Lnut S | 7 | | | | | | | | | S.A. | |
| 교 | 11. MARITAL STATUS 1 Never Married 2 | Married | FORCES? | T EVER IN U.S. AI | | | | | | NIC ORIGIN? (Specify in, Puerto Rican, atc.) | Yes or No- | 14. RACE Black, | - American Indian, White, atc. |
| BY | 3 Widowed 4 Divor | | IF YES, GIVE Y | MAR OR DATES | | | YES | 2 📉 NO | Specif | у: | | Specify Whit | /: |
| | 15, DECI | EDENT'S EDU | ICATION | 16a. Di | ECEDENT'S | USUAL O | CCUPATIO |)N | | 16b. KIND OF | BI ICINECC/IN | | |
| COMPLETED | (Specify only Elementary/Secondary (0- | highest grade | | (C | Bive kind of B. Do NOT u | work done | | | ng | los Karb or | D001111207111 | | |
| 3 | 8 | 12) | College (1-4 or 5 | | itche | 7 | | | | Shoe (| Compar | nv | |
| No. | 17. FATHER'S NAME (First, Mi | ddle, Last) | | 100. | 100110 | | | 18. MOT | HER'S NA | ME (First, Middle, Maid | | -1 | |
| | Calvin Miner | | | | | | | | | ine Harba | | | |
| BE | 19a. INFORMANT'S NAME (Ty | | | 19 | b. MAILING | ADDRESS | (Street a | | | Route Number, City or | | ip Code) | |
| 2 | Cora G. Buro | ger | | | | | | | | Hagersto | | | nd 21740 |
| | 20a, METHOD OF DISPOSITION 1 X Burlal 2 □ Cremation | | | 20b. PLACE | AND DATE | OF DISPOS | ITION (No | me of | | DATE 20c. | LOCATION - | - City or Tow | rn, State |
| | 1 M Burlal 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other | n 3 ∐ Ram (Specify) | noval from State | cemetery, cri | Lawn | other place) Mem | oria | l Pa | rk 8 | 3-29-94 | Hagers | stown | Maryland |
| | 21. SIGNATURE OF FUNERAL | SERVICE LI | CENSEE | | | 22. | NAME A | ID ADDRE | SS OF FA | CILITY | | | |
| | He James | 1 | NoTIL | 4.4 | | | | s A. | | - | | | Lvd. North |
| | 23. PART I. Enter the di | (R) A | and place in a | vu | anth Da | <u>F'u</u> | nera | 1 Ho | me | Hage: | rstowr | 1, MD | 21742 |
| | ahock, of he IMMEDIATE CAUSE (Fin disease or condition resulting in death) | art taliure. | a. | aceius | run |) 1 | 1 | live | 0 | | | | Interval Between Onset and Death |
| | | | DUE TO | (OR AS A CONSE | OUENCE O | 0 | | | | | | | |
| ON | Sequentially list condition | ONSEQUENCE OF: | | | | | | | | | | | |
| AT | If any, leeding to immed cause. Enter UNDERLY! | | ENCE OF): | | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or injurt that initiated events resulting in death) LAST | DUE TO | NF): | | | | | | | | | | |
| CE | | | d | | | | | | | | | | |
| AL | PART II. Other aignificer | nt condition | | - 11 | | in the un | derlyin | g cause : | given in | | AN AUTOPSY | | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO |
| EDICAL | | | ug popu | grotales | n | | | | | 1 YES | 2 🗆 NO | | COMPLETION OF CAUSE OF DEATH? |
| ME | | | Marco | el Mel | 111 | | | | | | | | 1 YES 2 NO |
| | | | 1 Dritt | exTMEL | lills | | | | | | | | |
| N N | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | | | | | | ACE OF D | EATH (Ch | neck only one) | | | |
| SI | 1 YES 2 NO | | HOSPITAL: | ER/Outpatient | 3 🗆 DOA | 4 Nur | | e 5 🗆 Re | esidence | 6 Other (Specify) | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | | 20s. DATE OF (Month, L | | 28b. TIN | IE OF | 28c. INJ WO | URY AT | | 28d. DESCRIBE HO | W INJURY O | CCURED | |
| ВУ | | Pending nvestigation | | | | М | | rES 2 | NO | | | | |
| COMPLETED | 3 Sulcide 6 0 | Could not be letermined | 28e. PLACE (building, | OF INJURY — At he, etc. (Specify) | ome, farm, | street, fact | ory, offic | • | | 281. LOCATION (Stre City or Town, St | et and Numberte) | er or Rural Ro | oute Number, |
| Ë | 29a. CERTIFIER 1 CERTI | FYING PHYS | ICIAN: To the best or | f my knowledou 4 | eath orange | and no observ | lme date | and stee | and d | to the cause(a) and | | eted | |
| ME. | nen) | | | | | | | | | | | | and manner as stated. |
| E C | 295. SIGNATURE AND TITLE | - | R (1) | | | _ | | | ENSE NUI | | _ | TE-BIGAED | Mgnth, Day, Year) |
| m | Signu | el | (leeu | | | | | | D266 | SEE | 1 | 170 | 190 |
| 2 | 30. NAME AND ADDRESS OF | PERSON WI | O COMPLETED CAU | SE OF DEATH (ITE | M 27) (Type | , Print) | | | D366 | 333 | | 100 | 1 |
| | Samuel Chan | | | | | | Hage | reto | רוגיור | MD 21740 | | | |
| | 31. DATE FILED (Month, Day,) | (bar) | 32. REGISTRA | AR'S SIGNATURE | 110 | au j | inde | | VALLE | TT 21140 | | | |
| - 1 | AUG 3 | U 1994 | of white | canoran-7 | man | | | | | | | | 2.753 |



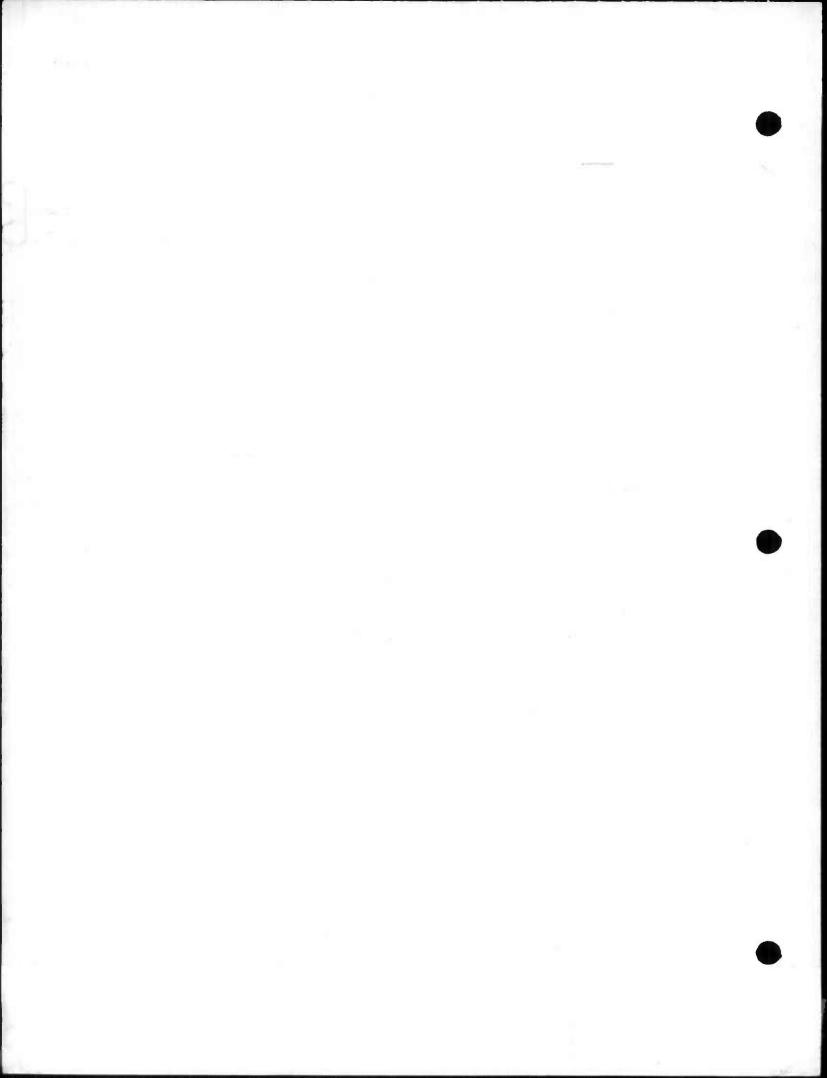
| | | ITEM: 4. PER PERSUNAL | KEP. FILM 6-72 | 0 2/2/95 t | .t | | | 34 | 20104 |
|--|--------------|--|--|--------------------------------|----------------------------------|---|---|---------------------|--|
| | | FOR 1 - STATE REGISTRAR | STATE OF MARYL | | | HEALTH AND N | MENTAL HYGIEN REG. NO | | |
| | | | VIRGIECM | PAKE CA | AMPER | | 2. DATE OF DEATH MONTH OF 8 7 42 | 74-94YE | 3. TIME OF DEATH 3 45 P |
| 38 | , | 4. SOCIAL SECURITY NUMBER 219-03-60614061 | 1 D M 2 F 8 | in yrs. lest birthday) 1 YRS. | IF UNDER 1 YEAR MONTHS DAYS | HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 6-21-19 | 213 00 | HRTHPLACE (State or Foreign country) Maryland |
| (Z) | TOR | 98. FACILITY NAME (If not institution, give s Dor. Gen. Hosp RESIDENCE OF DECEDENT | | | | or Location of DE bridge | ATH | Dor | chester |
| | DIRECTOR | 10a. STATE 10b. COUNT | or. | | y, town on Loc abridg | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| in. ansit perm | FUNERAL | 824 Washington | | | | 101. ZIP CODE 21613 | | 10g. CITIZEN | OF WHAT COUNTRY? |
| -0020 ing physician. the buria-transit | BY FUI | 11. MARITAL STATUS 1 Never Married 2 Married 3. Widowed 4 Divorced | 12. WAS DECEDENT EVER II FORCES? 1 1 YES IF YES, GIVE WAR OR D | 2 NO | If yes, | ECENDENT OF HISPAN apocity Cuban, Maxicai ES 2 NO Specity | | | RACE — American Indian, Black, White, atc. Specify: Black |
| AND 21215-0020 the hospital or attending physician detached for use as the burial-tranonce. | LETED | 15. DECEOENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT us | work done during se retired.) | TION most of working | 16b. KIND OF BU | SINESS/INDUST | |
| MARYLAND retained by the hospit 5 should be detached notified at once. | E COMPLET | 17. FATHER'S NAME (First, Middle, Last) | 5+ onroe F. L | Teacl ake | ner | 1200 | ME (First, Middle, Meiden Dennard | | |
| MAR e retained le 5 should notified | TO BI | 19a. INFORMANT'S NAME (Type/Print) Millie Lake | · · · · · · · · · · · · · · · · · · · | | | et and Number or Rural F | Coute Number, City or You Glen Burn | vn, State, Zip Code | |
| AORE, ge 6 may be irector, page | | 20a. METHOD OF DISPOSITION SE Burlai: 2 Cremation 3 Ram E Donation 5 Other (Specify) | oval from Stata cen | netery, crematory or o | ther place) | (Name of | 2 27 | cktown | |
| BALTIMORE, MARYI hours after death. Page 6 may be retained by d in by the funeral director, page 5 should be or removal. | | 21. SIGNATURE OF FUNERAL SERVICE LI | H. Boars | Lley | | Hubbard | Lewis | | rdley F/H e,Md.21613 |
| 1 5 E | | 23. PART I. Enter the diseases, or shock, or heart failura. IMMEDIATE CAUSE (Final disease or condition resulting in death) | List only one cause on e | ach line. | not enter the r | | h aa cardlac or reap | | |
| C 6876 executed and com to burial. | NTION | Sequentially list conditions, if any, leading to immediate | · Meta | CONSEQUENCE O | c Co | ancer | | | 2 Mont |
| certificat nding phy Hygiene p | ERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or Injury thet initieted events resulting in death) LAST | DUE TO (OR AS / | A CONSEQUENCE O | F): | | | | |
| ORDS that the ed by the th and Mi | MEDICAL C | PART II. Other significent condition | ns contributing to deeth t | out not resulting | in the underly | ring ceuse given in | Part I. 24s. WAS AN PERFO | | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| AL he law has th | PHYSICIAN: M | DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL | | CAUSE OF | | YES NO | | | 1 TYES 2 NO |
| F VITAL SICIAN: The law certificate has the State Dep | YSIC | EXAMINER? 1 YES 2 NO | HOSPITAL: 1) Inputlant 2 ER/Out | | | ome 5 - Residence | | | |
| O FF is the part of the part o | ВУ РН | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. OATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY | | JURY 1 | INJURY AT WORK? YES 2 NO | 28d. OESCRIBE HOW 28f. LOCATION (Street | | |
| DIVISION OR ATTENDING F DIRECTOR: After I hours after death Item 28 Is mar | ETED | 3 Suicide 8 Could not be 4 Homicide detarmined | building, atc. (Spe | city) | | | City or Town, State |) | urai Pioure Number, |
| 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | COMPLE | (Check only | ICIAN: To the best of my know ER: On the beals of examination | | | | | | use(s) and menner as stated. |
| TO THE HOSPITAL TO THE FUNERAL BE filed within 72 IMPORTANT: IS | BE | 296. SIGNATURE AND TITLE OF CERTIFIE | R Boin | | _ | 29c. MCENSE NUM | | 29d. DATE SIG | GNED (Month, Day, Year) |
| . FFA | 일 | 30. NAME AND ADDRESS OF PERSON WI | O COMPLETED CAUSE OF O | ATM (ITEM 27) (See | Deint) | | | | 1 1 |

32. REGISTRAR'S SIGNATURE
Julia Davidson-Randall

8

31. DATE FILEO (Month, Day, Year)
AUG 2 6 1994

DHMH-16 Rev 1/89



FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCICAE

| | 1 - STATE REGISTRAR | OTHE OF I | CE | | ICATE | | | | MENIAL I | REG. NO. | E | | |
|---------------|--|----------------------------|---------------------------------|-------------|--------------|-------------|-----------------------|------------|----------------------------------|-----------------------------|-------------|-------------------|---|
| | t. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF | DEATH | | | 3. TIME OF OEATH |
| | Mary Virginia | CROS | SCO | | | | | | MONTH | DA | 1994 | YEAR | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last | hirthday | IF UNDER | 1 VEAD | IF UNDER | 24 MDR | Aug. | | 1994 | a BIDTH | 10:00 A M |
| - | 15-26-4740 | 1 M 2 X F | | YRS. | MONTHS | DAYS | HOURS | MIN | (Month, D | ay, Year) | | Countr | γ) |
| 1 | 9a. FACILITY NAME (If not institution, give st | | 64 | .,,,,, | 21 217 | | | | Mar. | 5, 19 | | | yland |
| œ | | | | | 96. CITY | | R LOCATIO | ON OF DE | ATH | | | NTY OF D | |
| 0 | Garrett County Men | norial Ho | ospital | | | 0ak | land | | | | G: | arret | t |
| DIRECTOR | 10s. STATE 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION | | | | | | 10d. INSIDE CITY | | | 104 INSIDE CITY | |
| <u>۳</u> | MD | Garrett | - | | | | Doc | er Pa | 0 mlr | | | | LIMITS? |
| | 10e. STREET AND NUMBER | | | | 104 | ZIP CODE | | alk | | 100 017 | 17511 05 11 | 1 X YES 2 NO | |
| RA | P.O. Box 3031 | | | | | 101. | ZIF CODE | | | | log, Cit | | |
| FUNERAL | 11. MARITAL STATUS | 40 400 0505050 | T EVER IN U.S. ARI | - | - | | | 215. | | | | US | |
| 3 | 1 Never Married 2 Married | FORCES? 1 | YES 2 N | | | f yes, spe | cify Cuba | n, Maxica | IIC ORIGIN? (9 n, Puarto Rica | | or No- | 14. RACE Black | — American Indian, c, Whita, etc. |
| ВУ | 3 Widowed 4 Divorced | IF YES, GIVE W | AR OR DATES | | | YES | 2 💢 NO | Specify | <i>t</i> : | | | Specif | [√] White |
| | 15. DECEDENT'S EDUC | ATION | 16a DEC | PEDENTIS | USUAL O | CCLIDATIO | M. | | 485 VI | ND OF BUS | MIEGO (IN | DIIOTRY | WILLE |
| I | (Specify only highest grade | completed) | (Gh | ve kind of | work done (| | | g | 100. Kil | ND OF BUS | SINE 33/INI | JUSTRY | |
| PL | Elamentary/Secondary (0-12) 5th | College (1-4 or 5 + | -) | | sewi | fo | | | | Hom | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | 1100 | SEWI | re | 48 MOTA | EDIC NA | ME (First, Midd | Hom | | | |
| | onas | Johnson | | | | | | | _ | | | | |
| BE | | Johnson | 100 | MAILING | ADDRESS | (Ctonal o | | nna | Poute Number, | ee | | | trick |
| 2 | enneth H. Crosco | | | | | | | | | | | , | |
| 1 | 20a. METHOD OF DISPOSITION | | | | | - | | er P | ark, M | | | | |
| | 1 😾 Burlel 2 □ Cremation 3 □ Ramo | eval from Stata | 20b. PLACE A cemetery, crer | netory or o | ther plecel | | | | 1 | 20c. LO | | | , |
| | 4 Donation 5 Other (Specify) | cuber A | Garre | ett | | | Garo | | 8/21 | 0a | kland | d, MI |) |
| | ~ W ~ | 101 | | | 22. | | | | neral | Home | | | |
| | (Dieblen H | Moco | | | | | | | nd St. | | kland | 1. MD | 21550 |
| | 23. PART I. Enter the diseases, or c | omplications the | t caused the dec | eth. Do | not enter | the mo | de of dyl | ng, such | h ss cardied | or reepi | ratory ar | rest, | Approximete |
| | shock, or heert fellure. I IMMEDIATE CAUSE (Fine) | list only one cau | ise on eech line. | , | 1/ | 1 | , | , 1 | / | | | | Interval Between Onset and Death |
| | disesse or condition | (| 2 in alux | to | Lka | axt | / | 5/2 | 1/1 | | | | Sudden |
| | resulting in death) | DUE TO | (OR AS A CONSEO | UENCE O | F): 4.4 | | - | -/4 | / | • | / | | budden |
| 2 | | 40 | stevis | | My | ~~ | cerdial /yfavation su | | | | | Sudden | |
| 은 | Sequentially list conditions, if any, leading to immediate | DUE TO | OR AS A CONSEO | UENCE O | F): | The | 000 | | 1000 | 100 | 1/07 | | badden |
| S | CAUSE (Disease or injury | | | | , | • | | | | | | | |
| Ē | that initiated events | DUE TO | (OR AS A CONSEO | UENCE O | F): | | | | | | | _ | |
| CERTIFICATION | resulting in deeth) LAST | l | | | | | | | | | | | |
| | PART II. Other significant conditions | contribution to | death but not re | neultine. | In the un | dadulaa | | data de la | Don't o | | | Lau | |
| DICAL | / 1 | de | watti but not re | 1 | / | deriying | ceuse g | iven in | - 1 | a. WAS AN PERFOR | MED? | 246. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| ă | Congestiv | e 1100 | 41 7 | 4/1 | ve | | | | 1 | YES Z | NO | | OF DEATH? |
| ME | | | | | | | | | | | | | 1 TES 2 NO |
| PHYSICIAN | | | | | | | | | | | | | |
| 5 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER | | ACE OF O | EATH (Che | eck only one) | | | | |
| YSI | t VES 2 NO | 1 Xinpetient 2 | ER/Outpetient 3 | □ DOA | | | 5 🗆 Re | sidence | 6 Other (S | pecify) | | | |
| 표 | 27. MANNER OF DEATH | 28a. DATE OF (Month, Da | | 28b. TIN | IE OF | 28c. INJI | JRY AT RK? | | 28d. DESCR | BE HOW II | NJURY OC | CURED | |
| 8≺ | 1 Netural 5 Pending 2 Accident Investigation | | | | М | 1 🗌 Y | ES 2 | NO | | | | | |
| | 3 Suicide 8 Could not be | 28s, PLACE O building, | F INJURY — At horate. (Specify) | ne, tarm, | street, tact | ory, offica | | | 28t. LOCATIO | ON (Street a own, State) | ind Number | r or Rural R | loute Number, |
| COMPLETED | 4 Homicide datarmined | 10 | | | | | | | , | ,, | | | |
| 7 | 29a. CERTIFIER I CERTIFYING PHYSIC | CIAN To the best of | my knowladge, das | ith occurr | ed at the ti | lme, data | and place, | and dua | to the cause(| a) and man | ner aa ata | ted. | |
| N | OTHE 2 MEDICAL EXAMINED | | | | | | | | | | | |) and manner as stated. |
| | 29b, SIGNATUME AND DIVERTIESER | | | | | | 29c. LICE | | | - | | | |
| 8 | (3) | | | | | Į | | | | ŀ | Zyd. DAT | SIGNED | (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUS | SE OF DEATH ATEM | 27) /Time | Print | | 1 |)239 | 17 | | 0/ | 18/01 | 4 |
| | Dr. Robert Gorals | | 311 N. | | | t | Oak I | and | MD | 21550 |) | .71 | |
| _, | | | D'S SIGNATURE | Loui | . LII O | ٠., | Jaki | anu, | רוט . | ~ 1J)(| , | | |
| 4 | AUG 2 4 199 | 4 Juli | SALUEL ALL P | 1 11 | | | | | | | | | 1 |
| / 1 | THE RESERVE | TI JULIAN CL | A STATE MANAGER LEVEL | TOUR! | | | | | | | | | - 1 |

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within, cours after death. Page 6 may be retained by the hospital or attending to THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use askine be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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| | this | Will | a de |
| The common of th | NR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached | er death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | le marked or item 23 shows any injury or other teaments areas the modified averaged as according as according |
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| | FOR | | | | | | | | | | | | | |
|-------------------|--|----------------|------------------------------|-----------------------------------|-----------------------------|--------------|----------------|-----------|-----------|------------|--------------------------------|---|------------|--|
| | 1 - STATE REGISTRAR | | STATE OF I | MARYLAND C | / DEPAR ERTIF | | | | | MENT | AL HYGIEN REG. NO | _ | | |
| | 1. DECEDENT'S NAME (First, | Middle, Lest) | | | | | | | | | E OF DEATN | | | 3. TIME OF DEATH |
| | Maxine | Elsie | CLOS | SE | | | | | | Aug | тн 22, | 1994 | YEAR | 1:30 A M |
| | 4. SOCIAL SECURITY NUMBER | ER | 5. SEX | 6. AGE (In yrs. le | ast birthday) | IF UNDER | | IF UNDER | | 7. DAT | E OF BIRTN rith, Day, Year) | | 8. BIRTI | IPLACE (State or Foreign |
| | 181-18-6268 | | 1 □ M 2 💢 F | | YRS. | MONTHS | DAYS | HOURS | MIN. | | e 20, | 1919 | Mar | vland |
| ~ | 9a. FACILITY NAME (If not ins | | | | | 9b. CITY | , TOWN C | R LOCATI | ON OF DE | | | | NTY OF E | 4 |
| Ď. | Garrett Cou | nty Me | emorial F | lospital | | | 0al | cland | <u>1</u> | _ | | Garrett | | |
| рінестов | 10a. STATE | , | 10c. CITY, TOWN | | | | WN OR LOCATION | | | | 10d, INSIDE CIT | | | |
| | MD | | Garre | tt | | 24.77 | | | | | | LIMITS? | | |
| AL | 10e. STREET AND NUMBER | | | | | | 101 | ZIP COD | | | | 10g. CIT | ZEN OF | WHAT COUNTRY? |
| FUNERAL | P.O. Box 34 | 3 | | | | | | | 2154 | 41 | | | USA | 1 |
| 5 | 11. MARITAL STATUS | | 12. WAS DECEDEN | T EVER IN U.S. A | | | | | | | IN? (Specify Yes | or No- | 14. RACI | E — American Indian, k, White, etc. |
| BY | 1 Never Married 2 1 8 3 Wildowed 4 Divort | | IF YES, GIVE Y | | | | | 2 ⊠ NO | | | nicen, etc.) | | Spec | ity: |
| | 15. DECE | DENT'S EDUC | CATION | 160 D | ECEDENT'S | HEHAL O | COLIBATIO | 100 | | 100 | | | | White |
| | (Specify only Elementary/Secondary (0- | highest grade | completed) College (1-4 or 5 | | Give kind of e. Do NOT u | work done | | | g | 100 | Sb. KIND OF BU | SINESS/INC | DUSTRY | |
| 4 | 8th | / | Contage (1-4 of 5 | <i>'</i> | Hous | sewif | e | | | | Home | ٩ | | |
| COMPLETED | 17. FATNER'S NAME (First, Mic | Idle, Last) | | | | | | 18. MOT | NER'S NA | ME (First, | Middle, Maiden | | | |
| BE (| Ernest : | S. | Mosser | | | | | Al | .vena | a | Ρ. | Sh | ank | |
| 6 | 19s. INFORMANT'S NAME (7) | pe/Print) | | | | | | | | | mber, City or Tow | | Code) | |
| | Alex Close | | | | | | | | atts | svil | le, MD | | | |
| | 20a. METNOD OF DISPOSITIO | 3 🗆 Ramo | oval from State | 20b. PLACE cemetery, cr | ematory or o | ther place) | | | | 1 | | CATION — | | |
| | 4 Donation 5 Other (| | ENGET. | <u> [Garre</u> | tt Co | . Me | mori | al C | arde | ens | 8/ 2 5 0a | aklan | d, M | ID |
| | ► Q. M | 1. 1 | the | | | | | | | | Home | | | |
| _ | 22/00/ | Ley N. | Dank | 2 | | \bot | 32 5 | Se | cond | l St | ., Oak. | land, | MD | 21550 |
| | | art fallure. L | Int only one cau | t causad tha di se on each lin | eath. Do r e. | not antar | tha mo | da of dyl | ng, sucl | h an ce | rdiec or reapi | ratory an | eat, | Approximata Interval Batween |
| | IMMEDIATE CAUSE (Fina disease or condition | | D | | | | | | | | | | | Onset and Death |
| | resulting in death) | > , | Respirat | OR AS A CONSE | | E). | | | | | | | | days |
| _ | | - | | | 0.7 | , | ia O | hatm | uo t i | T | D., 1 | ry Disease years | | |
| 5 | Sequentially list conditions, Due to (or as a consequence of): Severe , End-stage Chronic Obstructive Pulmonary Disease years DUE TO (or as a consequence of): | | | | | | | | | | | | | |
| 2 | cause. Enter UNDERLYIN CAUSE (Disease or Injury | | Acute Br | | | | | | | | | | | days |
| | that initiated events resulting in death) LAST | | DUE TO | (OR AS A CONSE | QUENCE O | F): | | | | | | | | |
| CERTIFICATION | | | | | | | | | | | | | | |
| 1 | PART il. Other significen | conditions | contributing to | deeth but not | reculting | n the un | derlying | cause g | lven in | Part I. | | AUTOPSY | 24b. | WERE AUTOPSY FINDINGS |
| 음 | | | | | | | | _ | | | PERFOR | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| ME | | | | | | | | | | | | 44 | | 1 TES 2 NO |
| ä | | | | | | | | | | | | | | |
| PHYSICIAN: MEDICA | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOSPITAL: | | | OTHER | | ACE OF D | EATN (Che | ock only o | one) | | | |
| 14S | 1 YES 2 XNO | | 1 1 Inpatient 2 | | | - Y | | _ | aldence | | er (Specify) | | | |
| | | ending | (Month, De | | 28b. TIM | URY M | 28c. INJU | | | 28d. DE | SCRIBE NOW II | NJURY OC | CURED | |
| P. | 2 Sudalda | rveatigation | 26s. PLACE O | F INJURY — At he | ome, farm, s | street, fact | | | NO | 28f LO | CATION (Street # | and Number | or Purel 6 | Institu Mismbar |
| | 3 Suicide 6 Could not be datarmined 26s. PLACE OF INJURY — At home, fan building, stc. (Specify) | | | | | | | | | | | OCATION (Street and Number or Rural Route Number, ty or Town, State) | | |
| COMPLETED | 290. CERTIFIER 1 X CERTIF | FYING PHYSIC | CIAN: To the best of | my knowledge de | ath occum | ad at the fi | ma data | and place | | | | | | |
| | | | | | | | | | | | | | |) and manner ea stated. |
| | 296. SIGNATURE AND TITLE C | | | | | | | 29c, LICE | | | | | | (Month, Day, Ybar) |
| BE | Sohn T. 7 | ush: | TIL D.C |), | | | | | 3723 | | ſ | | 8/23 | |
| 임 | 30. NAME AND ADDRESS OF | | | E OF DEATH (ITE | М 27) (Туре, | Print) | | - 11 | 5123 | | | | 0/23 | 1 34 |
| | Dr. J. T. Tu | | | D. Box | 67, F | rien | dsvi | 11e, | Mar | ylar | nd 21 | 531 | | |
| | 31. DATE FILED (Moort) Day, Ye AUG 2 | 7 100 | 32. REGISTRA | R'S SIGNATURE | 1 | | | | | | - | | | |
| í. | 1100 2 | エリンプ | 1 , illa do | KINGROW- M | vocal. | | | | | | | | | |

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marked,

DIRECTOR: After the hours after death vitem 28 is mark

TO THE HOSPITAL OF THE FUNERAL DE FILED WITHIN 72 HORDERTANT: If IN

94 26187 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR July 25, Francis Paul Campaqnoli 1994 8:19 A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 1 M 2 XF 12/10/1915 578-30-3440 Washington. D. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Beach Drive Mechanicsville St. Mary's RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland
100. STREET AND NUMBER t 🗌 YES 2 🙀 NO St. Mary's Mechanicsville FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 86 Beach Drive 20659 U.S.A. 12. WAS OECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Mexican, Puarto Rican, stc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Narried 1 TYES 2 NO Specify: BY Specify: 3 Widowed 4 Divorced WW II White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade year Supervisor Post Office 17. FATHER'S NAME (First Middle (ast) 18. MOTHER'S NAME (First, Middle, Meiden Sumame) Nicholas Campagnoli Carmella Giangiulio BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Jennie Campagnoli 86 Beach Dr. Mechanicsville, Maryland 20659 20a. METHOO OF DISPOSITION
1 № Burlel 2 □ Cremetion 3 □ Removel from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State OATE 1 S Buriel 2 Cremation 3 L 4 Donation 5 Other (Specify) Resurrection Cemetery 7/30/1994 Clinton, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE. Mattingley-Gardiner Funeral Home, P.A.

23. PART i Enter the diseases, of complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest,

Approx.

Approx. 20650 **Approximate IMMEDIATE CAUSE (Finel Onset and Death** diseese or condition Arrest ardine resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): congestive CERTIFICATION Sequentially list conditions, If any, leeding to immediate cause. Enter UNDERLYING hears Filwe CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceusa given in Part i. 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS MEDICAL AMILABLE PRIOR TO COMPLETION OF CAUSE F. brill-bon . Choric 1 TYES 2 W NO OF DEATH? renalinsulahia 1 TYES 2 THO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 12 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA **EXAMINER?** OTHER: 1 TES 2 NO 27. MANNER OF DEATH 28a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 5 Pending investigation 1 YES 2 NO BY 28s. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 3 Sulcide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER

(Chack and) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

K. meht mg

30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

2. REGISTRAR'S SIGNATURE

36206

Shanti Medical Center, Leonardtown, Maryland

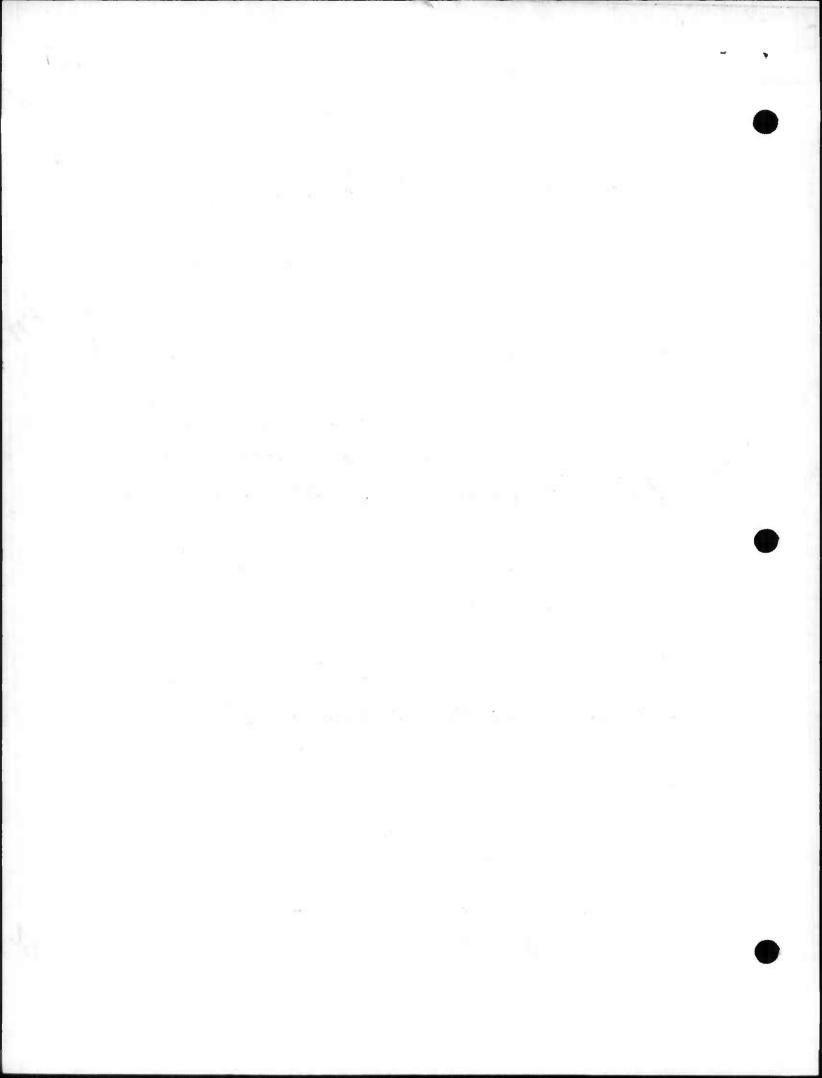
31. OATE FILED (Month, Day, Year)

JUL 12 8 1994 4

Kiran Mehta, M.D.

DHMH-16 Ray 1/89

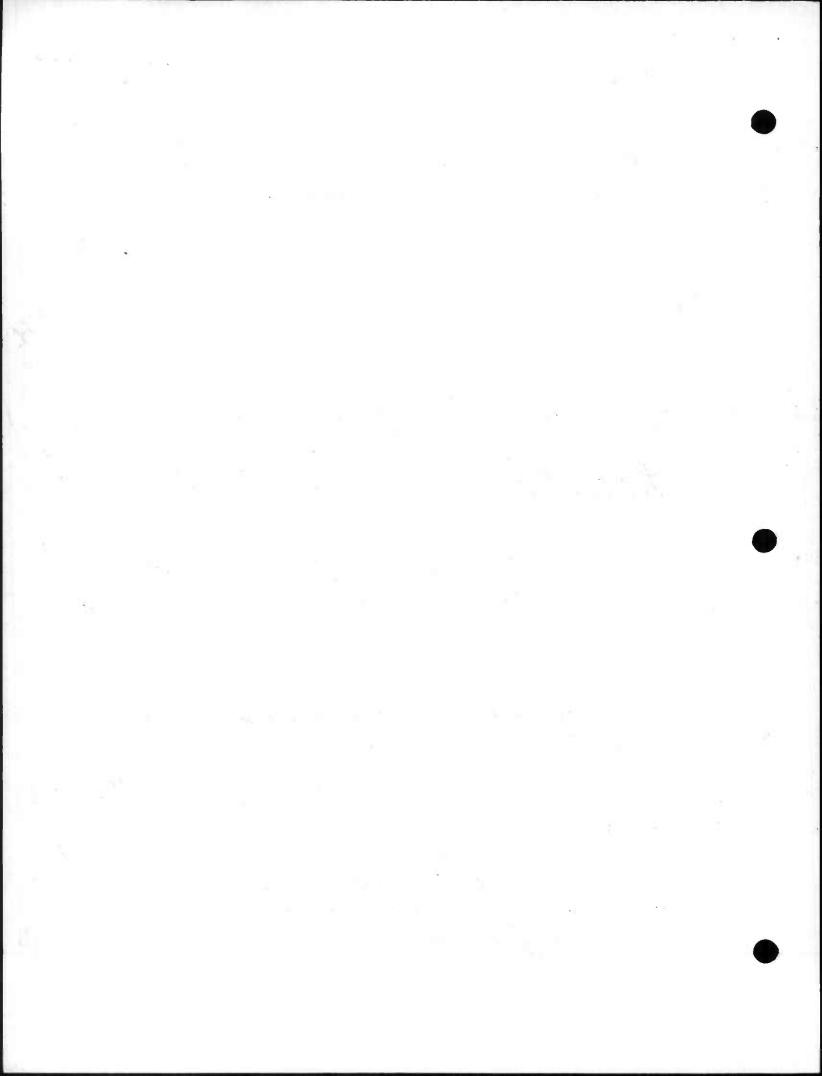
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| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | BALTIMORE, MARYLAND 21215-0020 |
|---|---|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician. | er death. Page 6 may be retained by the hospital or attending physician. |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burnal-traffis be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | the funeral director, page 5 should be detached for use as the buriat-trags |
| IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | il examiner must be notified at once. |

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | . HYGIENE |
|---|-----------|
| CERTIFICATE OF DEATH | REG. NO. |

| | 1 - STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTM CERTIFIC | | | MENTAL HYGIEN | E | | | | |
|------------------|---|--|--|--------------------|--------------------|---|---------------------|--|--|--|--|
| Ţ, | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | |
| ŝ | Jean | Marie | C] | arke | | July 26, 1 | | 10:00 P M | | | |
| | 4. SOCIAL SECURITY NUMBER 5 | S. SEX 8. AGE (III | n yrs. lest birthday) | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BIRT | HPLACE (State or Foreign | | | |
| 1 | 578-42-8876 | □ M 2 🔀 F | 61 YRS. MOI | ITHS DAYS | HOURS MIN. | NOV 10 . 19 | 932 Vi | | | | |
| | 9e. FACILITY NAME (If not institution, give stree | | | CITY, TOWN O | R LOCATION OF DI | | 9c. COUNTY OF | rginia OEATH | | | |
| DIRECTOR | St. Mary's Nursin | g Center | | Leon | amtown | St. Mary's | | | | | |
| H | 10a. STATE 10b. COUNTY | _ | | WN OR LOCAT | | | 10d. INSIDE CIT | | | | |
| | Maryland St. Ma | ry's | Hol | lywood | | | LIMITS? 1 YES 2 NO | | | | |
| FUNERAL | 10e. STREET AND NUMBER | | | 100 | ZIP CODE | | tog. CITIZEN OF | WHAT COUNTRY? | | | |
| ğ | Rt. 1 Box 891 Clar | | | | 20636 | | U.S. | Α. | | | |
| 5 | 11. MARITAL STATUS 1: | 2. WAS DECEDENT EVER IN FORCES? 1 YES | | | | NIC ORIGIN? (Specify Yes | | CE — Americen Indien, ck, White, etc. | | | |
| BY | 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR DAT | TES | | 2 NO Specif | | Whi | elly: | | | |
| | t5. DECEDENT'S EDUCAT | TION I | 18e. DECEDENT'S USU | AL OCCUPATIO | N | 155 KIND OF BUIL | SINESS/INDUSTRY | .te | | | |
| H | (Specify only highest grade cor | mpleted) | (Give kind of work life. Do NOT use rel | done during mos | | 166. KIND OF BUS | SINESS/INDUSTRY | | | | |
| 7 | 11th Grade | College (1-4 or 5+) | Owner/Ope | erator | | Bar & | Restaur | ant | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Maiden | Surneme) | | | | |
| | Eugene | Edwards | | | Anna | Louise | De | an | | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAILING ADI | DRESS (Street a | nd Number or Rural | Route Number, City or Town | n, State, Zip Gode) | | | | |
| 2 | Charles M. Clarke | | Rt.1 Bo | x 891, | Holly | wood, MD. | 20636 | | | | |
| | 20e. METHOD OF DISPOSITION t X Buriet 2 Cremetion 3 Remove | 20b. | PLACE AND DATE OF D | SPOSITION (Na | na of | DATE 20c. LO | CATION — City or 1 | Town, State | | | |
| | 4 Donetion 5 Other (Specify) | St. | atary, crematory or other p | Cemete: | _y | Но | llywood, | Maryland | | | |
| | 21. SIGNATURE OF PUMERIAL SERVICE LICEN | | | 22. NAME AN | D ADDRESS OF FA | ardiner Fur | oral Har | 70 D A | | | |
| - 1 | Michael | Davies |) | | | | | yland 20650 | | | |
| | 23. PART /Enter the diseees, or con | nplicatione that ceused | the death. Do not | | | | | Approximate | | | |
| | shock, Dr heart fallure. List IMMEDIATE CAUSE (Final disease Dr condition reaulting in death) e | Sepsi | 5 | | | | | Intervel Between Onsst and Death | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in deeth) LAST E. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | |
| AL (| PART II. Other significant conditions of | contributing to deeth bu | it not resulting in th | ne underlylng | ceuse given in | Part I. 24a. WAS AN PERFOR | | b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO | | | |
| PHYSICIAN: MEDIC | | | | | | 1 _ YES 2 | | COMPLETION OF CAUSE OF DEATH? | | | |
| ME | | | | | | | 0 | t 🗆 YES 2 🗀 NO | | | |
| ä | DID TOBACCO USE CO | NTRIBUTE TO | AUSE OF DI | EATH YE | S NO | D | | | | | |
| CE | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | IOSPITAL: | | | ACE OF DEATH (Ch | eck only one) | | | | | |
| YSI | 1 YES 2 NO 1 | ☐ Inpatient 2 ☐ ER/Outpa | itlent 3 DOA 4 | Nursing Home | 5 🗆 Reeldence | 6 Other (Specify) | | | | | |
| H | 27. MANNED OF DEATH 1 Natural 5 Pending | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJU WOI | JRY AT RK? | 28d. DESCRIBE HOW II | NJURY OCCURED | | | | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | | | | ES 2 NO | | | | | | |
| | 3 Suicide S Could not be 4 Homicide determined | 28e. PLACE OF INJURY - building, etc. (Specif | — At home, ferm, atree (y) | t, factory, office | | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| COMPLETED | (Check only one) 2 MEDICAL EXAMINER: | N: To the best of my knowle On the basis of examination | | | | | | (e) end manner ee stated. | | | |
| 88 | 196. SIGNATURE AND TITLE OF CERTIFIER | 1 1. | In , | 12 | 29c. LICENSE NUI | MBER 230 | 29d. DATE SIGNE | D (Mogth, Day, Year) | | | |
| 2 | David C. Allen, M. | | nardtown, | | nd 2065 | 50 | 1 | 1-11 | | | |
| | 31. DATE FILED (Month, Day, Year) 2, 8, 1994 | 32. REGISTRAR'S SIGNA | yne Kardall | | | ···· | | | | | |



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 28 hours are 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fined in by the former officer, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, the medical examiner must be notified at once.

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| | FOR 1 - STATE REGISTRAR | STATE OF I | MARYLAND / | DEPAR | RTMENT OF | HEALTH | AND | MENTAL | HYGIEN REG. NO. | E | | |
|--|--|----------------------|---|--------------------------|--|------------|-------------|------------------------------|--|--------------|-----------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | ra I | BILAC | | | | | 2. DATE O | OF DEATH DA | | EAR | 3. TIME OF DEATH 9:53 A M |
| 1 | 4. SOCIAL SECURITY NUMBER 214-32-5689 | 5. SEX | 6. AGE (In yrs. In: | st birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | HOURS | 24 HRS. | 7. DATE O (Month, 7-19 | ——— 15 Быятн Day, Ybar) -1915 | Ti | BIRTHP | LACE (State or Foreign |
| OB B | 90. FACILITY NAME (If not institution, give s ATLANTIC GENER | RAL HOSPI | TAL | | 9b. CITY, TOWN | BERL | | EATH | | 9c. COUNTY | | ATH |
| DIRECTOR | 10e. STATE 10b. COUNT | WORCESTE | R | | TY, TOWN OR LOCA BERLIN | TION | | | | · | | IOd. INSIDE CITY LIMITS? I YES 2 [X] NO |
| FUNERAL | 100. STREET AND NUMBER 9617 SEA HAWK HI | IGHWAY | | | 16 | H. ZIP COD | 21 8 | 11 | | | | IAT COUNTRY? |
| 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 (X NO Specify: Specify: | | | | | | | | | White, etc. | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) [She kind of work done during most of working file. Do NOT use retired.) [She kind of work done during most of working file. Do NOT use retired.) [ONE STIC 17. FATHER'S NAME (First, Middle, Lest) [INITATION IN THE CONTRACT OF THE CON | | | | | | | | | | | | |
| | 17. FATHER'S NAME (First, Middle, Lost) UNKNOWN | N | 1 | | | 18. MOT | | | ddle, Melden : BETH F | | | |
| TO BE | 190: INFORMANT'S NAME (Typo/Print) CLARA LEONARD | | 19 | b. MAILING ADE | RESS SA | ond Number | or Rural | Route Numbe | | | ode) | |
| | 20e. METHOD OF DISPOSITION 1 VI Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | oval from State | 20b. PLACE cemetery, cre | AND DATE Omatory or o | OF DISPOSITION (N Other place) GREEN | ame of | | 8-20 | | IN, M | | n, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | B. Joe | ku | | JOLLE SAL | Y MEN | ORI/ | AL CHAMD. 2' | APEL, | 1213 | JEF | RSEY ROAD, |
| | 23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition | Complications the | t caysed the de | eth. Do | not enter the me | ode of dy | ing, suc | ch es cerdi | oc or respir | atory erres | t, | Approximate interval Between Onset and Death |
| z | resulting in death) | DUE TO | (Off AS A CONSE | QUENCE O | a or | Ser. | 4 | نف | میں | | • | |
| CERTIFICATION | Sequentielly list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST | c. OUE TO | OR AS A CONSECUTION OF AS | OUENCE O | F): | Ja | Q | me | • | | | |
| L CER | PART II. Other significent condition | d | deeth but not r | resulting | In the underlyin | a ceuse o | given in | Part I. | 24a. WAS AN | MITTOPSY | 24h W | /ERE AUTOPSY FINDINGS |
| MEDICA | | | | | | | | | PERFORI | MED? | C | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPHAL: | - /2 | | 26. P | LACE OF O | EATH (Ch | eck only one) | | | | |
| PHYS | 1 VES 2 NO 27. MANNER OF DEATH | | | 28b. TIM | 4 Nursing Hon IE OF 28c. IN. | JURY AT | aldence | | | JURY OCCUP | ED | |
| ED BY | 1 Netural S Pending 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE O | | | | YES 2 | NO | 281. LOCAT | TON (Street as Town, State) | nd Number or | Rural Rou | ite Number, |
| LETE | 4 Homicide determined | | | ath course | | | | | | | | |
| COMPLET | (Check only one) 2 MEDICAL EXAMINE | R: On the basis of a | | | | | | | | | euse(s) s | ind manner es stated. |
| TO BE | 296. BIGHAQUIRE AND TITLE OF CERTIFIER | 100 | | | | 29c. LICE | H 36 | MBER 17 | | 29d. DATE SI | S | 15/94 |
| | Scott SUGENCY | O O | GF33 | 4 | Print) | 34 t | yu. | EB | enci | N → | 15 | 21811 |
| | 31. DATE FILED (Month, Day, Year) AUG 1 8 1994 | | ANGLER RE | delle | | , | | | | | | |

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FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

| | REGISTRAR | | CE | RTIF | ICATE C | F DEAT | ГН | | REG. NO |). | | |
|---------------|--|-------------------------|------------------|--------------|----------------|------------------------------|------------|----------------|-------------|------------|--------------|---------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | A. | | | 2. DATE OF | DEATH | DAY | | 3. TIME OF DEATH |
| | Earnest | C1vde | | D | uval1 | Jr. | | Augus | | | 1994 | 11:42 P: |
| | 4. SOCIAL SECURITY NUMBER | | AGE (In yrs. les | | IF UNDER 1 YE | R IF UNDER | 24 HRS. | 7. DATE OF | BIRTH | - | 8. BIRTI | IPLACE (State or Foreign |
| | 219-80-6666 | 1 💢 M 2 🗍 F | 40 | YRS. | MONTHS DA | B HOURS | MIN. | Aug . | 18. 1 | 1953 | Count | irginia |
| | 9e. FACILITY NAME (If not institution, give si | treet and number) | | | 9b. CITY, TO | VN OR LOCATION | ON OF DE | | | | UNTY OF D | |
| <u>۳</u> | Dhysicians Money | mial Hami | L-1 | | | | | | | 1,500 | 01 | 1 |
| ĸ | Physicians Memor | rial Hospi | тат | | LLa | Plata | | | | 1 | Cha | rles |
| DIRECTOR | 10a. STATE 10b. COUNTY | | | 10c. CIT | Y, TOWN OR L | CATION | | | | | | 10d. INSIDE CITY LIMITS? |
| 5 | Maryland St. Maryland | ary's | | Med | chanic | sville | | | | | | 1 YES 2 NO |
| A | 10e. STREET AND NUMBER | | | | | 10f. ZIP CODE | E | | _ | 10g. CI | TIZEN OF | WHAT COUNTRY? |
| FUNERAL | 1195 Dogwood Lane | е | | | | 206 | 59 | | | | U.S. | Α. |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT E | | | 13. WAS | DECENDENT O | OF HISPAN | IIC ORIGIN? (| Specify Ye | e or No- | 14. RAC | E — American Indian, |
| | 1 Never Married 2 Married | FORCES? 1 [| | 10 | | , specify Cube YES 2 X NO | | | en, etc.) | | Speci | k, White, etc. |
| 8√ | 3 Wildowed 4 Divorced | | | | | | , , | | | | Whi | |
| 쁘 | 15. DECEDENT'S EDUC (Specify only highest grade | CATION completed) | 16a, DE | CEDENT'S | USUAL OCCUI | ATION | na. | 16b, K | IND OF BU | ISINESS/II | VOUSTRY | |
| 9 | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. | Do NOT us | se retired.) | mout or worten | ry. | | _ | | | |
| MP. | 10th Grade | | Ca: | rpet | Mecha | nic | | | arpe | et Co | ompan | Y |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | - 2.2 | | | | | _ | ME (First, Mid | | | | |
| BE (| EarnestClyde Duva | 3TT | | | | Ha | zel | 7 | Alber | rta | Me | cCloud |
| 10 | 19e. INFORMANT'S NAME (Type/Print) | | | | ADDRESS (Str | | | | | | | |
| F | Mary E. Duvall | | | 1195 | Dogwo | od Lane | e, M | echani | icsvi | lle, | MD | 20659 |
| | 20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Remo | auni inno State | | | OF DISPOSITIO | (Neme of | | DATE | 20c. LC | CATION - | - City or To | own, State |
| | 4 Donetion 5 Other (Specify) | THE HOLL STATE | Charle | es Ma | emoria | Garde | ens | 8/9/94 | 1 Le | onar | dtow | n, Maryland |
| - 1 | 21. SIGNATURE OF FUNERAL SERVICE LIC | EMSEN) | 1 | | 22. NAM | E AND ADDRES | SS OF FA | CILITY | | 7 | 77 | e, P.A. |
| | Muchael | To B. | Also. | 0 . 1 | | | | | | | | |
| - 17 | 23. PART I. Enter the diseases, or o | complication that o | am | 11 | P.U | DOX a | 270, | Leona | irate | own, | Mary. | land 20650 |
| | effock, or heart fellure. | List only one ceuee | on each line | ent. Do r | ot enter the | mode or dyi | ing, auci | n aa carela | c or resp | iratory a | rreat, | Approximate interval Between |
| | IMMEDIATE CAUSE (Finel disease or condition | A 1 1 | 111 | | | | | | | | | Onest and Deati |
| | resulting in death) | . Alcoh. | | | | 10.202 | <u></u> | | | | | hours |
| | | DUE TO (OF | AS A CONSEC | DUENCE OF | F): | | | | | | | |
| O | Sequentially list conditions, | b. DHE TO COL | AS A CONSEC | UENOE O | h. | | | | | | | |
| F | If any, leeding to immediate cause. Entar UNDERLYING | 502 10 (61 | AS A CONSEC | DENCE OF | 7: | | | | | | | |
| 임 | CAUSE (Disease or Injury | DUE TO (OF | AS A CONSEC | NIENCE O | D. | | | | | | | |
| Ē | thet initiated events resulting in death) LAST | 332 13 (3) | , no n consco | OLIVOL OI | <i>y.</i> | | | | | | | j |
| CERTIFICATION | | 4 | | | | | | | | | | |
| | PART ii. Other aignificant condition | e contributing to de | ath but not n | eaulting | in the under | ying ceuse g | given in | Part i. 24 | a. WAS AN | | r 24b | WERE AUTOPSY FINDINGS |
| DICAL | | | | | | | | | PERFO | | | MAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | | | | | -, | | OF DEATH? |
| - | DID TOBACCO USE | CONTRIBUTE | TO CAU | SE OF | DEATH | YES [| 1 NC | KIC | | | | 1 123 2 100 |
| ¥ | 25. WAS CASE REFERRED TO MEDICAL | | | | | . PLACE OF D | | | | | | |
| PHYSICIAN: ME | EXAMINER? | HOSPITAL: | VOutpatient 3 | DOA | OTHER: | Home 5 🗆 Ra | | | Pannifer) | | | |
| Ĭ | 27. MANNER OF DEATH | 28s. DATE OF INJ | URY | 28b. TIM | E OF 28c | INJURY AT | TO-CO-IICA | 28d. DESCR | | INJURY O | CCURED | |
| | 1 Netural 5 Pending | Month, Day, | | | URY 1 | WORK? | Mo | 011 | Lake | lar | rs de | |
| ğ | 3 Suicide & Could get be | 28e. PLACE OF IN | | | | | | 261, LOCATI | ON (Street | and Numb | or Burni | Route Number, |
| | 4 Homicide 6 Could not be | building, etc. | (Specify) | | | | | City or | lown, State |) | No. | -14.6 |
| 9 | 29e, CERTIFIER | NANC | | | //\/_===/\ | | 7 | MIT | _ | ains | 14/2 | HIM. |
| COMPLETED | (Check only CERTIFYING PHYSI | | | | | | | | | | | |
| ē I | 2 XMEDICAL EXAMINE | H: Un the basis of exam | ination end/or i | nvestigatio | n, in my opink | n, death occur | red at the | time, date en | d place, er | nd due to | the couse(s | s) end menner se stated. |
| BE (| 296. SIGNATURE AND TITLE OF CERTIFIER | 0) ; | - | 1 | 1 - | | ENSE NUN | | | 29d. D/ | TE SIGNED | (Month, Day, Year) |
| ը 2 | HOW HOW | 18/24) L | (0 Dy | W// | WE | D- | -273 | 48 | | 1 8 | 16/60 | |
| F | 30. NAME AND ADDRESS OF PERSON WHO | D COMPLETED CAUSE (| OF DEATH (ITE | 1 27) (Type, | Print) | | | | | | | |
| | Howard M. Haft N | 1D P.O. B | ox 164 | 7 Wa | ldorf. | Md. 20 | 0604 | | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S | SIGNATURE | 011-1 | 1. | | - V V T | | | | | |
| | AUG 0 9 19 | 34 yourd | MINISTEN, I | West Told | v | | | | | | | |

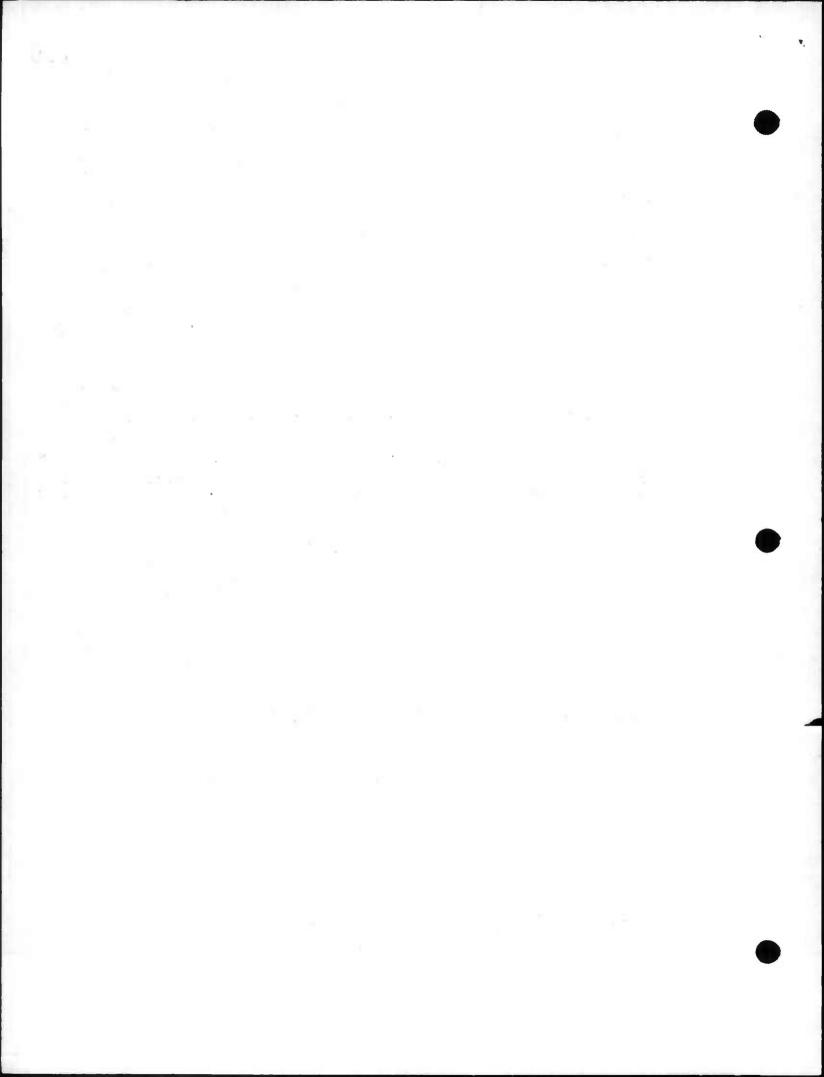
8760, BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within, nours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

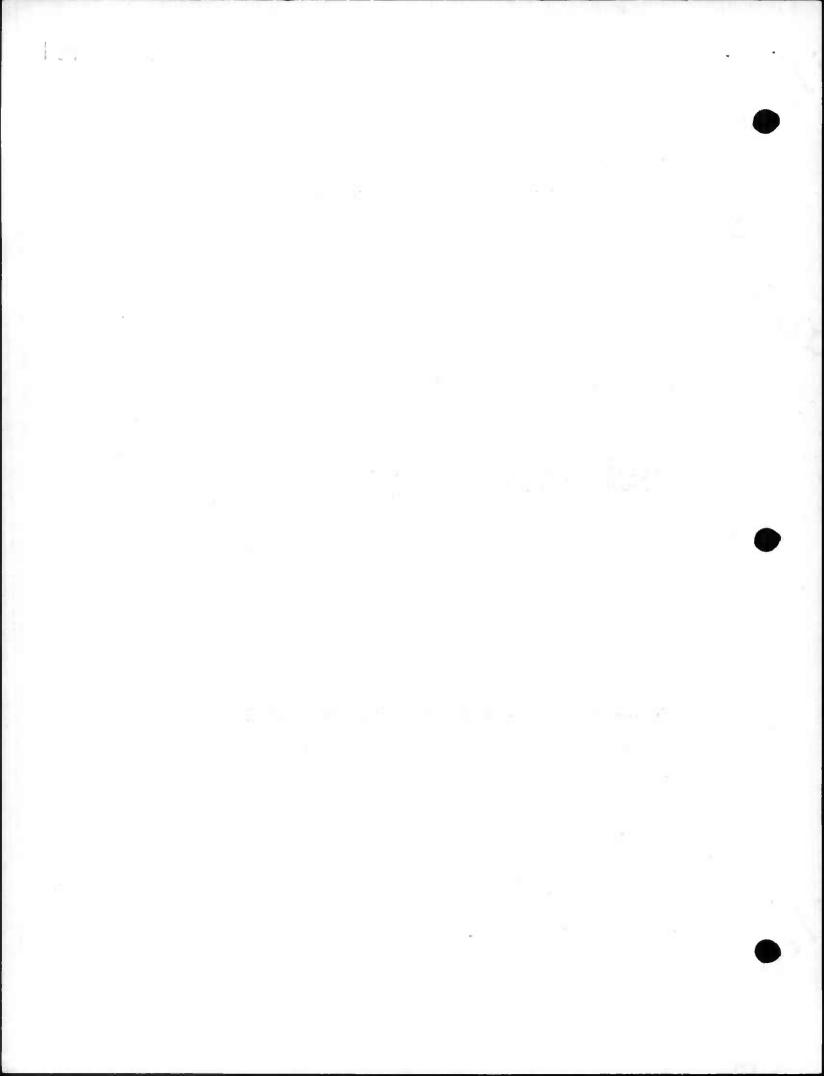
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-18 Rev 1/89



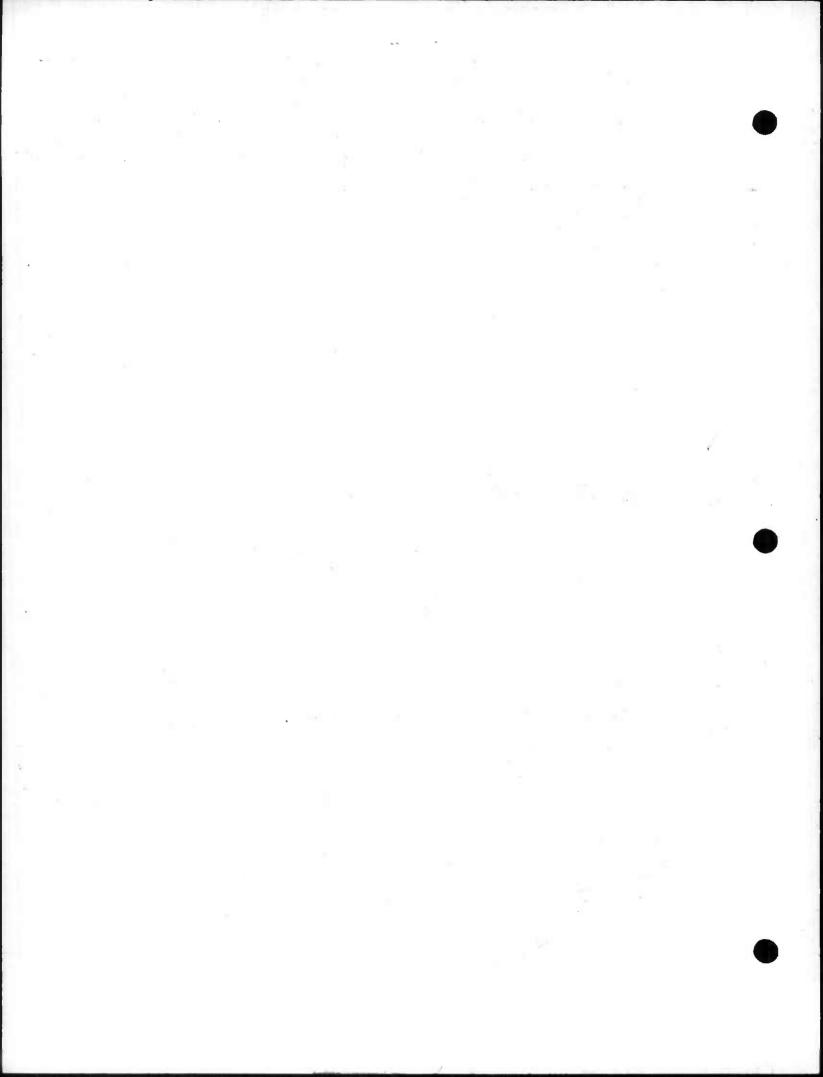
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending properties of the pro |
|--|
| IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| |

| | FOR STATE REGISTRAR | STATE OF MAI | | | F HEALTH AND OF DEATH | | YGIENE EG. NO. | | |
|------------------|---|------------------------------------|-----------------------------------|----------------------------------|--|------------------------------|---------------------------------|--------------|---|
| - 0 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF D | EATH DAY | 3 | . TIME OF DEATN |
| ŝ | Carrie Davis | | | | | August | | 94 | 8:00 A M |
| - 6 | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. | AGE (In yrs. last birthday | | | 7. DATE OF BI | RTN | | ACE (State or Foreign |
| | 579-30-3411 90. FACILITY NAME (If not institution, give si | 1 🗆 M 2 🔀 F | 90 YRS. | | AYS HOURS MIN. | November | 15,1903 | Sout | h Carolina |
| œ | | | | | WN OR LOCATION OF E | | | ITY OF DEA | |
| DIRECTOR | P.O. Box 373, Lin | coln Avenu | le | Lexi | ington Par | k | St. | Mary | s |
| <u> </u> | 10e. STATE 10b. COUNTY | | | ITY, TOWN OR L | OCATION | | | 1:1 | 0d. INSIDE CITY |
| ㅎ | Maryland St. | Mary's | Т. | ovingta | n Park | | | 1 | LIMITS? |
| 甘 | 10e. STREET AND NUMBER | 11017 0 | | CATHEC | 101. ZIP CODE | | 10g. CITIZ | | AT COUNTRY? |
| E | P.O. Box 373, Lin | coln Avenu | le. | | 20653 | | Unit | 2 hat | tates |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EX | ER IN U.S. ARMED | | DECENDENT OF HISPA | | | | - American Indian, White, etc. |
| BY F | 1 X Never Merried 2 Merried 3 Widowed 4 Divorced | FORCES? 1 | | | s, specify Cuben, Maxic YES 2 NO Spec | | etc.) | Specify: | White, etc. |
| | | | | | | | | Blac | k |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | completed) | (Give kind o | S USUAL OCCU work done during | PATION og most of working | 16b. KIND | OF BUSINESS/IND | USTRY | |
| ا ت | Elementary/Secondary (0-12) | College (1-4 or 5+) | | use retired.) | | | | | |
| N N | 17, FATNER'S NAME (First, Middle, Last) | | поше | maker | | | | | |
| | Alfred Davis | | | | | Burnett | Maiden Surname) | | |
| 8 | 19e. INFORMANT'S NAME (Type/Print) | | 106 MAII II | Annese /o | reet and Number or Rura | | Anna Paris Chata Tin | 0 | |
| 일 | Louise H. Bludson | | | | 3, Lincoln | | | | ark MD |
| | 20a. METHOD OF DISPOSITION | | 20b. PLACE AND DAT | | | | 20c. LOCATION — (| | |
| | 1 № Buriel 2 ☐ Cremetion 3 ☐ Remo | | First Bar | other place) | hurch Ceme | terv | Levingto | n Par | -k MD |
| | 21. SIGNATURE OF STOPERAL SERVICE YO | Wise W | 77 | | E AND ADDRESS OF F | | JOHE 11800 | 11 1 41 | К, 112 |
| | Edward N. Brin | Du | . M0005 | | sfield Fu | | | | |
| \neg | 23. PART i. Enter the diseeaes, or o | | | | Box 279, | Leonar | dtown, Ma | aryla | |
| | shock, or heart failure. | List only one cause | on each line. | | mode of dynig, au | on as bordies (| or respiratory and | rot, | Approximate interval Between |
| | IMMEDIATE CAUSE (Fine) disease or condition | C | 0 | 5 / | 4 7 | 5.11 | 44.0 | | Onset and Death |
| | reaulting in death) | DUE TO (OR | S A CONSEQUENCE | OF): | car 1 | 77.0 | 700 | | - |
| z | | | | | | | | | |
| 을 I | Sequentisity liet conditions, if any, leading to immediate | DUE TO (OR | AS A CONSEQUENCE | OF): | | | | | |
| 5 | Cause, Enter UNDERLYING CAUSE (Disease or injury | B | | | | | | | |
| | that initiated events reaulting in deeth) LAST | DUE TO (OR | AS A CONSEQUENCE | OF): | | | | | |
| CERTIFICATION | | d | | | | | | | |
| AL O | PART ii. Other significent condition | s contributing to de | eth but not reaultin | in the under | iying ceuse given in | Part i. 24a. | WAS AN AUTOPSY | | ERE AUTOPSY FINDINGS |
| | | | | | | | PERFORMED? | C | MAILABLE PRIOR TO OMPLETION OF CAUSE |
| Ä | | | | | | | , | | F DEATH? |
| PHYSICIAN: MEDIC | DID TOBACCO USE C | ONTRIBUTE T | O CAUSE O | DEATH | YES NO | | | | |
| S | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 7 | 6. PLACE OF DEATH (C | heck only one) | | | |
| YS! | 1 TYES 2 NO | 1 Inpatient 2 ER | VOutpstient 3 🗆 DOA | OTHER: 4 - Nursing | Nome 5 Residence | 8 Other (Spe | city) | | |
| 표 | 27. MANNER OF DEATH 1 Nstural 5 Pending | 28e. DATE OF INJ (Month, Day,) | | ME OF 286 | NJURY AT WORK? | 28d. DESCRIB | E NOW INJURY OCC | URED | |
| B | 2 Accident investigation | | | | YES 2 NO | | | | |
| | 3 Suicide 8 Could not be 4 Nomicide determined | 28e. PLACE OF IN building, stc. | JURY — At home, farm (Specify) | , street, factory, | office | 281, LOCATION City or Tow | (Street end Number n, State) | or Rural Rou | te Number, |
| COMPLETED | 290. CERTIFIER | | | | | , | | | |
| P P | (Check only CERTIFYING PNYSI | CIAN: To the best of my | | | | | | | |
| S | | R: On the beals of exemi | instion end/or investigs | tion, in my opini | on, death occured at th | e time, date end p | place, end due to the | csuse(e) e | nd manner as stated. |
| H H | 296. SIGNATURE AND TITLE OF GERTIFIER | 12 | | | 29c. LICENSE NU | IMBER | 29d. DATE | SIGNED (A | fonth, Day, Year) |
| ē. | milm | 42 mo | | | D14285 | | - 1 | 5-12 | -94 |
| | 30. NAME AND ADDRESS OF PERSON WHO | D COMPLETED CAUSE C | | | | | | | |
| | William D. Boyd I 31. DATE FILED (Month, Day, Year) | I M.D. | 17 Jeffer | son Str | eet, Leon | ardtown | Marylar | nd 20 | 650 |
| | | 4 Julia Da | SIGNATURE P | | | | | | |
| | MIII. I K IMM | (1. II. JTH | 120 1 MAN IN M A W | | | | | | , |



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| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely be filed within 72 hours after death with the State Dept. of Hearth and Mental Hygiene prior to burial, crematic | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, crematine with the state Dept. of Health and Mental Hygiene prior to burial, crematine with the State Dept. of Health and Mental Hygiene prior to burial, crematine with the Table State Dept. of Health and Mental Hygiene prior to burial, crematine or the state of the State Dept. of Health and Mental Hygiene prior to burial crematic or the state of the State Dept. of Health and Mental Hygiene prior to burial crematic or the state of the State Dept. of Health and Mental Hygiene prior to burial crematic or the state of the State Dept. of Health and Mental Hygiene prior to burial crematic or the State Dept. of Health and Mental Hygiene prior and completely the State Dept. of Health and Mental Hygiene prior to burial crematic or the State Dept. of Health and Mental Hygiene prior to burial crematic or the State Dept. of Health and Mental Hygiene prior to burial crematic or the State Dept. of Health and Mental Hygiene prior to burial crematic or the State Dept. of Health and Mental Hygiene prior to burial crematic or the State Dept. |

| - | negis inan | | | CENTIF | ICAL | E UF | DEA | ın | H | IEG. NO. | | | | |
|---------------|--|--|-----------------|---------------------------------|-------------|-------------|----------------|-------------|---------------------|--------------------|---------------|--------------|---|----------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF MONTH | 0.45 | r | YEAR | 3. TIME OF DEATH | |
| | EDGAR GIRI | | EDMUN | | | | | | AUGUST 22,1994 | | | | 12:40 AM | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. | | IF UNDER | DAYS | HOURS | 24 HRS. | 7. DATE OF I | BIRTH ly, Year) | | Countr | HPLACE (State or Forei | |
| | 577-10-6673 | 1 ☑ M 2 ☐ F | 79 | YRS. | | | | | Aug (| 30, | 191 | + No | orth Car | oT1 |
| ~ | 9e. FACILITY NAME (If not institution, give | | | | | | | ON OF DE | ATH | | 9c. COU | NTY OF D | EATH | |
| DIRECTOR | PHYSICIANS MEMOR | RIAL HOSP | [TAL | | I | A PI | LATA | | | | CHA | RLES | , | |
| ដ្ឋ | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT | Y | | 10c. CIT | Y, TOWH (| OR LOCAT | TION | | | | | | 10d, INSIDE CITY | = |
| E | Maryland Cha | rles | | - | | | bacc | | | | | | LIMITS? | . 1 |
| 5 | 10e. STREET AND NUMBER | TIES | | 1 1 | OLL | _ | 1. ZIP COD | | | | 40 - 017 | 1750 05 1 | 1 TYES 2X NOWHAT COUNTRY? | <u> </u> |
| FUNERAL | | D1 | | | | 10 | 206 | | | | | S.A | | |
| N N | 1142-B Shirley | D L V CL . | EVER IN II C | ADMED | 1 40 | <u></u> | | | 10.0010110.00 | | | | | - |
| | 1 Never Merried 2 Married | FORCES? 1 | YES 2 | MNO NO | | If yes, sp | ecify Cube | n, Mexican | IC ORIGIN? (S | n, etc.) | or No- | 14. RACI | E — Americen Indian, k, White, etc. | · |
| B∀ | 3 Widowed 4 Divorced | IF YES, GIVE W | AR OR DATES | | | 1 TYES | 2X NO | Specify: | : | | | Wh | Îte | - 1 |
| | 15. DECEDENT'S EDU | CATION | 180. | DECEDENT'S | USUAL O | CCUPATION | ON | | 16h KIN | ID OF BUS | INFSS/IN | DUSTRY | | |
| E I | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 + | | (Give kind of a life. Do NOT us | work done | during mo | ost of working | ng | -113 | | | | | - 1 |
| 7 | 12 | College (1-4 or 5 + | | Servi | ce : | Man | ger | | Ca | r De | eale | rsh | ip | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | - | HER'S NAM | ME (First, Midd | | | | | - |
| Ö | Thomas Edmun | dson | | | | | | lia | | unds | | | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | | | 19b. MAILING | ADDRES | S (Street a | and Number | or Rumi A | loute Number, (| City or Town | State 7 | n Codel | | \dashv |
| 5 | Betty E. Edmun | dson | ŀ | | | | | | | | | | o, MD 20 | 677 |
| | 20e. METHOD OF DISPOSITION | | 20b. PLA | CE AND DATE | | | | | DATE | _ | | | own, State | |
| | 1 K Burlel 2 Cremetion 3 Ren 4 Donetion 8 Other (Specify) | noval from State | Oak | crematory out | the Cen | nete | erv | 8 | 124 | | | • | ch, VA | - 1 |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | | 008/7 | | | | | | | | | me, Inc | |
| | M. A. | 05/6 | 7 | , | | Are | hart | -Ecl | hols | Fune | eral | . Ho | me, Inc | . |
| _ | Huylan (| -ceno | 200 | | | P.0 | . BC | x 5 | b/ La | . Pla | ita, | MD | 20646 | |
| | 23. PART i. Enter the diseeses, or shock, or heart failure. | List only one caus | se on each i | line. | not enter | the mo | ode of dy | ing, auch | as cardiac | or reapir | atory ar | reat, | Approximate interval Bets | |
| | IMMEDIATE CAUSE (Final disease or condition | C . 1 | . 11 | 1 | 1 | | 1 | | 0 | A | | | Onset and E | Death |
| | reaulting in death) | . CVW | ren | Va | Cu | N | 13 | rec | ega | N | 8 | | | |
| | | DUE TO | OR AS A CON | SEQUENCE O | F): | a | 1 | 1. 1 | () | | | | | |
| S | Sequantially list conditions, | DUE TO | NO. | SEQUENCE | gu | 5 | (VV | 400 | 100 | | _ | | | |
| FA | If any, leading to immediata cause. Enter UNDERLYING | \ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | Two T | SEGUENCE | | 0) | J | | | | | | | - 1 |
| 윤 | CAUSE (Disease or Injury that Initiated events | C. DUE TO | OR AS A CON | SEQUENCE OF | FI: | | _ | | | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | | | | | ı |
| 빙 | | d | | | | | | | | | | | | |
| EDICAL | PART II. Other significant condition | ns contributing to | death but no | ot reaulting | in tha u | nderlyln | g cause | given in i | Part I. 244 | PERFORI | | 24b | WERE AUTOPSY FIND AVAILABLE PRIOR TO | |
| 음 | | | | | | | | | 1 | YES 2 | NO | | COMPLETION OF CAL OF DEATH? | |
| ME | | | | | | | | | | | | | 1 YES 2 NO | |
| | DID TOBACCO USE | CONTRIBUTE | TO CA | USE OF | DEA | TH Y | res [| I NO | | | | | | |
| Y | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | | | LACE OF D | EATH (Che | ck only one) | | | | | |
| PHYSICIAN: | 1 TES 2 THE | HOSPITAL: | ER/Outpatient | 3 🗆 DOA | 4 Nur | | 10 5 🗆 Re | eldence (| 8 Other (Sc | pecify) | | | | |
| E | 27. MANNER OF DEATH | 28e. DATE OF (Month, Da | | 28b, TIM | E OF | | URY AT | | 28d. DEŞCRI | BE HOW IN | JURY OC | CURED | | |
| ВУ | 1 Natural 5 Pending 2 ccident Investigation | | | | M | 1 🗆 | _ | NO | | | | | | |
| | 3 Suicide 8 Could not be | 28e. PLACE OF building, | INJURY — At | home, ferm, | street, fec | tory, offic | | | | N (Street ar | nd Numbe | r or Rural I | Route Number, | 111 |
| COMPLETED | 4 Homicide determined | | | | | | | | only or re | wir, Gratey | | | | - 1 |
| 2 | 29e. CERTIFIER 1 CERTIFYING PHYS | ICIAN: To the best of | my knowledge, | , death occurr | ed at the t | lime, date | end place | , end due t | to the cause(e | e) end men | ner ee sta | ted. | | |
| S | 070) 2 MEDICAL EXAMINI | | | | | | | | | | | | a) end menner ee stat | ed. |
| - 11 | 296. SIGNATURE AND TITLE OF CERTIFIE | RIL | 2. | 1 | | | 29c. LIC | ENSE NUM | BER . | | 29d. DAT | re skonen | (Month, Quy, Year) | - |
| H | = / Simula | ndwy | W | } | | | 1 | 77 | 0150 | 9 | > 5 | 21- | 2791 | 1 |
| 임 | 30. HAME END ADDRESS OF PERSON WI | O COMPLETED CAUS | E OF DEATH (| ITEM 27) Hype | Print) | | | | | 1 | r (| 1. | - 1-01 | 44 |
| | 1 G. M. M. B | 21 1A13 | · lm | LA | 515 | T | RI. | Ni | 1.21 | 261 | 46 | | | 1 |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRA | | | | 10. | . 41 | , ,, | - 1 | - | , , , , | - | | |
| | AUG 24 199 | 4 Julia | Vauctor | Karball | | | | | | | | | | |
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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| SING | After | death | ma |
| TENC | DR: | ofter (| 28 Is |
| JR AT | IRECT | SULS S | E . |
| TALC | AL D | 72 hc | # # |
| OSPIT | JNER. | thin | N. |
| 포 | 표표 | ₩ pa | ORT |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with nours after death. Page 6 may be retained by the hospital or attending | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as t | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | CERTIFIC | ATE OF | DEATH | R | EG. NO. | | |
|-------------|--|--|---------------------|---|----------------|----------------------|------------------|--|
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) | | | I | 2. DATE OF D | EATH | | 3. TIME OF DEATH |
| | MARY LOU EISLEY | | | | JULY | 26, 1994 | YEAR | 2332 M |
| - 1 | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE | (In yrs. lest birthday) IF | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF B | IRTN | s. BIRTI | NPLACE (State or Foreign |
| | 305-36-9204 1□ № 2 💢 🖡 | 61 YRS. MO | NTHS DAYS | HOURS MIN. | (Month, Day | | Count | (ערי |
| | 9e. FACILITY NAME (If not institution, give street end number) | | CITY TOWN OF | R LOCATION OF DEA | | 20, 1933 | NTY OF C | |
| œ | The second secon | " | | | an . | | | |
| DIRECTOR | ST, MARY'S HOSPITAL | | LEONA | ARDTOWN | | ST | . MA | RY'S |
| 입 | 10e. STATE 10b. COUNTY | 10c. CITY, T | OWN OR LOCATION | ON | | | | 10d, INSIDE CITY |
| <u> </u> | MARYLAND ST. MARY'S | TEVT | NOTON T | ADIZ | | | | LIMITS? |
| - 1 | 100. STREET AND NUMBER | LEXI | NGTON F | ZIP CODE | | I too CIT | IZEN OF | WHAT COUNTRY? |
| FUNERAL | | | | | | | | 11.75 |
| | RT. 1. BOX 129 11. MARITAL STATUS 12. WAS DECEDENT EVER | MILLO ADMED | | 0653 | | | | STATES |
| 요 | 1 Never Merried 2 X Merried FORCES? 1 YES | 2 📉 NO | If yee, spec | NDENT OF NISPANI city Cuben, Mexicen | , Puerto Ricen | ecity Yes or No | 14. RACI Blac | E — American Indian, k, White, atc. |
| À | 3 Wildowed 4 Divorced IF YES, GIVE WAR OR I | DATES | 1 TYES | 2 NO Specify: | | | Spec | |
| | 15. DECEDENT'S EDUCATION | 16a. DECEDENT'S US | IIAL OCCUPATION | | Tab Milli | D OF BUSINESS/IN | WHI | 1E |
| COMPLETED | (Specify only highest grade completed) | (Give kind of work life. Do NOT use re | done during most | of working | TOO. KINI | OF BUSINESS/INI | DUSTRY | 11530 |
| ا ج | Elementary/Secondery (0-12) College (1-4 or 5 +) | | | | | | | |
| Ž I | 17. FATNER'S NAME (First, Middle, Last) | DAY CARE | WORKER | | | | | |
| ម | | | | 18. MOTNER'S NAM | | , Maiden Sumeme) | | |
| | LOUIS SCHALK | | | CLARA P | ARDUE | | | |
| 0 | 19e. INFORMANT'S NAME (Type/Print) | | | d Number or Rural Ro | | | | |
| - | HAROLD S. EISLEY | RT 1, B | 30X 129, | LEXINGI | ON PAI | RK, MARY | LAND | 20653 |
| | | b. PLACE AND DATE OF D | | ne of | DATE | 20c. LOCATION — | City or To | own, State |
| | 4 Donation 5 Other (Specify) | metery, crematory or other METROPOLIT | IAN CRE | MATORY | | VIRGIN | NIA | |
| . 1 | 21. THEMSTURE OF FUNERAL SERVINE LICENSEE | | | ADDRESS OF FAC | | IOMB | | |
| - 1 | William of Government | | | TIELD FUN | | | . | |
| \dashv | MICHAEL K. BLANKENSHUP) | | | | | | | LAND 20650 |
| J | 23. PART I. Enter the diseases, or complications that cause shock, or heart failure. List only one cause on | each line. | enter the mod | e or aying, sucn | ae cardiac | or reapiratory ar | rest, | Approximate interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | | | | | | | Onset and Dasth |
| | resulting in death) | grove. | o wias | v co | 2 ore | ~4 | | |
| | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | | |
| z I | Sequentially list conditions, | A CONSEQUENCE OF): | o U/no | May | E | tem s | | |
| RTIFICATION | ,, | A CONSEQUENCE OF): | | | | | | |
| 5 | CAUSE (Disease or Injury | | | | | | | |
| = | that initiated events DUE TO (OR AS | A CONSEQUENCE OF): | | | | | | |
| | resulting in desth) LAST | | | | | | | |
| CE | PART II. Other significant conditions contributing to death | hut not resulting in t | the underlying | cause Shien in E | and I are | . WAS AN AUTOPSY | | |
| DICAL | | | | | art I, 248 | PERFORMED? | 246 | AWAILABLE PRIOR TO |
| | hypetersion | _ D. M | ellit | h | _ 10 | YES 2 NO | | OMPLETION OF CAUSE OF DEATN? |
| ME | | | | | | | | 1 TYES 2 NO |
| ž | DID TOBACCO USE CONTRIBUTE TO | CAUSE OF D | EATH YE | S NO | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | | | CE OF DEATH (Chec | ck only one) | | | |
| 2 | 1 YES 2 NO 1 Inpetient 2 ER/Out | | THER: Nursing Nome | 5 - Residence 8 | Other (Spe | ecity) | | |
| Ŧ | 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | F 28c. INJU WOR | RY AT | 28d. DESCRIE | E NDW INJURY OC | CURED | |
| À | 1 Pending 2 Accident Investigation | | | ES 2 NO | | | | |
| | 3 Suicide 28e. PLACE OF INJUR | Y — At home, ferm, atre- | et, factory, office | | | N (Street and Number | r or Rural i | Route Number, |
| | 4 Homicide determined building, etc. (Spe | эснуј | | | City or Tox | vn, State) | | |
| ۱ ۳ | 290. CERTIFIER | and and an article and a second | | | | | | |
| COMPLETED | Check only One) 2 MEDICAL EYAMMED: On the heat of my knor | | | | | | | |
| 5 | one) 2 MEDICAL EXAMINER: On the basis of examination | on end/or investigation, is | n my opinion, de | ath occured at the t | ime, date end | place, end due to t | he ceuse(| e) end manner as stated. |
| # | 29b. SIGNATURE AND TITLE OF CEPTIFIER | | | 29c. LICENSE NUM | | 29d. DAT | E SIGNED | (Month, Day, Year) |
| 2 | 1cm n | 2 | | D36 | 206 | 0 | 117 | 06:17 |
| = | 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF D | EATH (ITEM 27) (Type, Pri | int) | | | | , , | , |
| | Kiron D. moht | , mo | 60 | 1) Navol | ton | N M | 0 2 | 0/12 |
| | | HATURE | | | . 00 | - / | | 06(1) |
| | 31. DATE FILED (Month, Day, Year) JUL 28 1994 | -Kardall | | | | | | |
| | 000.00 | Line Del Vision (S.E.) | | | | | | |

| | 1 - FOR STATE OF MARY REGISTRAR | | MENT OF H | | MENTAL HYGIE | | |
|----------------------|---|--|------------------------------|--|---|------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) Robert Alvin Evans | | | | 2. DATE OF DEATH MONTH August | | 3. TIME OF DEATH |
| ~ | .0 | E (In yrs. lest birthday) YRS. | MONTHS DAYS 9b. CITY, TOWN C | F UNDER 24 HRS. HOURS MIN. R LOCATION OF D | 7. DATE OF BIRTN (Month, Day, Year) August 1 | 8. Bif | Maryland |
| DIRECTOR | St. Mary's Hospital RESIDENCE OF DECEDENT 100. STATE 100. COUNTY | 10c CITY | Leona | rdtown | | St. 1 | Mary's |
| | Maryland St. Mary's | | ney Poi | | | Tan-arriven | LIMITS? 1 YES 2 NO |
| FUNERAL | P.O. Box 13 | | | 0674 | | United | d States |
| BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT, EVER FORCES? 1 Verence IF YES, GIVE WAR OR 1 9 4 4 — 1 9 | DATES | If yes, sp | | NIC ORIGIN? (Specify an, Puerto Rican, etc.) y: | St | ACE — American Indian, lack, White, etc. pecify: 1 t e |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | 18a. DECEDENT'S (Give kind of w life. Do NOT use | ork done during mo | | 16b. KIND OF | BUSINESS/INDUSTRY | Y |
| COMP | 1.2 17. FATHER'S NAME (First, Middle, Last) | Restau | eteur | 18. MOTNER'S NA | AME (First, Middle, Mald | ion Surname) | |
| BE (| Lewis Evans | | | | ret Long | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) Agnes C. Evans | | | | Route Number, City or | | |
| | | 0b. PLACE AND DATE O | | | | Marylar | nd 20674 |
| | 4 Donation 5 Dother (Specify) | emetery, cremetory or other factory of the land to the | er place) | | Gı | eat Mil | lls, MD |
| | 21. Signature of University Designation of the Edward N. Brinsfield. | / | Brins | | Funeral | | 4D 20650 |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury | A CONSEQUENCE OF |): | -tory | anc. | 8+. | Interval Between Onset and Death |
| PHYSICIAN: MEDICAL C | PART II. Other algnificent conditions contributing to death Chowice b Shrike (milet Chol | N PUIN | UNOY | Disce | PERF | AN AUTOPSY CORMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO |
| NAN | 25. WAS CASE REFERREO TO MEDICAL EXAMINER? | | 26. Pt | ACE OF DEATH (CI | neck anly one) | | |
| YSK | 1 VES 2 NO 1 Inpetient 2 ER/O | utpatient 3 DOA | OTHER: 4 - Nursing Norm | o 5 ☐ Realdenca | 8 Other (Specify) | | |
| ВУ РН | 27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation 28a. DATE OF INJURY (Month, Day, Year |) INJ | M 1 . | RK? 'ES 2 NO | 28d. DESCRIBE HO | N INJURY OCCURED | |
| | 4 Homicide detarmined building, etc. (S | RY — At homa, farm, s pecify) | reel, lactory, offic | | 281. LOCATION (Stre City or Town, Str | et and Number or Rur ite) | al Route Number, |
| COMPLETED | 29a. CERTIFIER (Check only 1 CERTIFYINO PNYSICIAN: To the best of my kind one) 2 MEDICAL EXAMINER: On the basis of examinat | | | | | | e(s) and manner as stated. |
| TO BE | 296. SIGNATURE AND TITLE OF CERTIFIER | NO | | 29c. LICENSE NU | MBER 206 | | ED (Month, Day, Year) |
| - | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF I | DEATH (ITEM 27) (Type, | Print) 2 Le | | | | 20650. |
| | 31. DATE FILEA (NOTE DO 1991) 1994 Julia David | Low-Randall | | | | | |

| 1.1 | , Middle, Last) | | | | ICATE O | DEA | | 2. DATE OF | REG. NO. | _ | | 3. TIME OF DEATH | |
|--|--|--|--|--|--|---|--|--|---|---|--------------------|--|--|
| Harry | , | | | F | re ma | 0. | JR. | MONTH | - 10A | -19 | 7 4947 | 0700 | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | 8. AGE (In yrs. la | net birthday) | IF UNDER 1 YEAR | | R 24 HRS. | 7. DATE OF | BIRTH | | B. BIRTHE | LACE (State or Foreign | |
| 220-03-496 | 51 | 1 💢 M 2 🗆 F | 80 | YRS. | MONTHS DAYS | HOURS | MIN. | 9-08- | 1913 | | NEW. | ARK, MD. | |
| Sa. FACILITY NAME (If not in | | | | | 9b. CITY, TOW | OR LOCAT | ION OF DE | EATH | | 9c. COU | NTY OF DE | | |
| | | LTH CARE | CENTER | | SALIS | SBURY | | | WIC | | | COMICO | |
| RESIDENCE OF DEC | 10b. COUNT | | | I 40. 00 | | | | | | | | | |
| MD. | | CESTER | | 10C. CI | NEWARI | | | | | | | 10d. INSIDE CITY LIMITS? | |
| 10e, STREET AND NUMBER | | DEGTER | | 1 | | 10f. ZIP COD | e- | | | 10+ CIT | | 1 YES 2 NO | |
| | RTE. | 2, TINDL | EY TOWN | ROAD | | 2 000 | 219 | 941 | | | JSA | TAL COUNTAIN | |
| 11. MARITAL STATUS | 100 | 12. WAS DECEDEN | IT EVER IN U.B. A | RMED | | ECENDENT (| | HC ORIGIN? (| Specify Yea | | | - American Indian, | |
| 1 Never Married 2 3 3 Widowed 4 Divo | | FORCES? 1 | YES 2 X | NO | If yes, | specify Cubi ES 2 XNO | an, Mexica | n, Puerto Ric | in, etc.) | | Black, Specify | White, etc. | |
| | EDENT'S EDU | | 16a, D | ECEDENT'S | USUAL OCCUPA work done during | TION | ina | 16b. K | ND OF BUS | INESS/IN | DUSTRY | | |
| Elementary/Secondary (0 | | College (1-4 or 5 | +) | b. Do NOT u | se retired.) | most or work | 19 | | 0 D1 15 D | | | | |
| 6th | | | | LABOR | KEK | | | | ARMER | | | | |
| 17. FATHER'S NAME (First, M HAR | | REMAN, SR | | | | 18. MOT | | ME (First, Mid GENE J | | | | | |
| 19a. INFORMANT'S NAME (1 CONWELL FO | | | | | OWHATTA | | | | | | | 01 | |
| 20a. METHOD OF OISPOSIT 1/□ Burlel 2 □ Crematic | ION | and took State | 20b. PLACE | ANDDATE | OF DISPOSITION | Nama of | | DATE | | ATION - | City or Tow | rn, State | |
| 4 Donation 5 Other | | toval from State | cemetery | W"BET | THE'CO UM | CHURC | CH | 8-22 | BER | LIN, | MD. | | |
| 21. SIGNATURE OF FUNERA | L SERVICE LI | CENSEE | .1 | | JOLLE | AND MARK | TORIA | ELTYCHA | PEL. | 1213 | JFR9 | SEY ROAD, | |
| Dar | Ma | D.X | Veller | 4 | SAL | SBURY | , MC | 218 | 01 | | | , | |
| 23. PART I. Enter the d | iseasea, or | complications the | t caused the d | eath. Do | not enter the r | node of dy | ing, suci | h aa cardla | or reapin | atory ar | reat, | Approximate | |
| IMMEDIATE CAUSE (Fir | | List only one cau | ae on eech iin | 10. | | | | | | | | Onset and De | |
| disease or condition | \rightarrow | Rev | al F | Fail | Re | | | | | | | years | |
| | | | (OR AS A CONSE | | | | | | | | | | |
| Sequentially itat condit | ions. | b | | | | | | | | | | | |
| if any, leading to imme | diate | DUE 10 | (OR AS A CONSE | EQUENCE O | NF): | | | | | | | | |
| CAUSE (Disease or inju | | C | (OR AS A CONSE | EOUENCE O | F): | | | | | | | | |
| | | DUE TO | | | | | | | | | | | |
| that initiated events resulting in death) LAS | т | DUE TO | 1201.00 | | | | | | | | | | |
| that initiated events resulting in death) LAS | | d | | | | | | | | | | | |
| that initiated events resulting in death) LAS | ent condition | dns contributing to | death but not | | 1 - | | _ | Part I. 2 | Ia, WAS AN A | | | WERE AUTOPSY FINDIN | |
| that initiated events resulting in death) LAS | ent condition | d. | death but not | rescu | las ? | disea | _ | | | WED? | | AWAILABLE PRIOR TO | |
| that initiated events resulting in death) LAS | ent condition | dns contributing to | death but not | rescu | 1 - | disea | _ | | PERFORI | WED? | | AMAILABLE PRIOR TO COMPLETION OF CAUS | |
| PART II. Other significe Change | ent condition | d. | death but not | rescu | la T Disso | ise. | se | _ ' | PERFORI | WED? | | COMPLETION OF CAUSE OF DEATH? | |
| PART II. Other significe TELLE C LUCY 25. WAS CASE REFERRED T EXAMINER? | ent condition | d. | death but not | rescu | la T Disso | disea | se | _ ' | PERFORI | WED? | | AVAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? | |
| PART II. Other significe TELLE S LANGE CASE REFERRED T EXAMINER? 1 YES 2 NO | ent condition | ns contributing to | death but not | nscu ng 3 DOA | 26. OTHER: 4 Nursing H | SE a PLACE OF C OTTO 5 R | Se DEATH (Ch | eck only one) 6 Other (5 | PERFORI | MED? | | AVAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? | |
| PART II. Other significe PART II. Other significe PART II. Other significe Chapter 25. WAS CASE REFERRED T EXAMINER? 1 YES 2 (NO) 27. MANNER OF DEATH | ent condition | ns contributing to | death but not M dio V P LUI) ER/Outpatient INJURY | ASCUL AG DOA 26b. TIR | 26. OTHER: 4 Nursing H | PLACE OF E NJURY AT WORK? | SEATH (Chi | eck only one) 6 Other (5 | PERFORM | MED? | | AVAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? | |
| PART II. Other significe Lucus 25. WAS CASE REFERRED T EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident | ent condition Claro CUS † | HOSPITAL: 1 Inpetient 2 28e. DATE OF (Month, D | death but not the dio v | 3 DOA | OTHER: 4 Nursing H ME OF JURY M 1 | PLACE OF E | SEATH (Chi | eck only one) 6 Other (S 28d. DESCF | PERFORI | MED? | CURED | AMAILABLE PRIOR TO COMPLETION OF CAUS: OF DEATH? 1 YES 2 NO | |
| PART II. Other significe Lucus 25. WAS CASE REFERRED T EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident | ent condition Claro OUS f | HOSPITAL: 1 Inpatient 2 280. PLACE O | death but not M dio V P LUI) ER/Outpatient INJURY | 3 DOA | OTHER: 4 Nursing H ME OF JURY M 1 | PLACE OF E | SEATH (Chi | eck only one) 6 Other (S 28d. DESCF | PERFORI | MED? | CURED | AMALABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO | |
| that initiated events resulting in death) LAS PART II. Other signification of the control of th | ent condition Class OUS † OMEDICAL Pending investigation Could not be determined | HOSPITAL: 1 Inpatient 2 28e. PLACE O building. | ER/Outpatient INJURY OF INJURY — A1 h etc. (Specify) | 3 DOA 26b. Till | 28. OTHER: 4 Nursing H 4E OF 28c. I JURY M 1 [street, factory, of | PLACE OF E OTHE 5 R NJURY AT WORK? YES 2 [ffice | DEATH (Chicago and | eck only one) 6 Other (S 28d. DESCF City or | PERFORM YES 2 Specify) HBE HOW IN ON (Street are) | NED? | CURED or Rural Ro | AMAILABLE PRIOR TO COMPLETION OF CAUS: OF DEATH? 1 YES 2 NO | |
| that initiated events resulting in death) LAS PART II. Other signification of the control of th | ent condition Claro OUS† TO MEDICAL Pending investigation Could not be determined | HOSPITAL: 1 Inpertent 2 28e. DATE 0 Month, D 28e. PLACE 0 building. | ER/Outpatient INJURY ay, Year) FINJURY — A1 h etc. (Specify) | 3 DOA 26b. Tiff | 26. OTHER: 4 Nursing H 4E OF 28c. I JURY M 1 [street, factory, of | PLACE OF COME 5 R NUMBER AT WORK? YES 2 [filce | DEATH (Christian NO NO NO NO NO NO NO NO NO NO NO NO NO | eck only one) 6 Other (S 28d. DESCF 28f. LOCATI City or | PERFORM YES 2 Sipecity) IBE HOW IN ON (Street are) ON (Street are) (a) end mans | NO NO NO NO NO NO NO NO NO NO NO NO NO N | CURED or Aural Ac | AMALABLE PRIOR TO COMPLETION OF CAUS OF DEATH! 1 YES 2 NO | |
| that initiated events resulting in death) LAS PART II. Other significe A TELLO S CLUBBLE 25. WAS CASE REFERRED T EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 2 Accident 3 Suicide 6 4 Homicide 29e. CERTIFIER (Check only one) 2 MED | ont condition Color OUS † OMEDICAL Pending investigation Could not be determined TIFYING PHYS ICAL EXAMINE | HOSPITAL: 1 Inpetient 2 28e. PLACE O building. | ER/Outpatient INJURY ay, Year) FINJURY — A1 h etc. (Specify) | 3 DOA 26b. Tiff | 26. OTHER: 4 Nursing H 4E OF 28c. I JURY M 1 [street, factory, of | PLACE OF COME 5 R NJURY AT WORK? YES 2 Titles and place in death occur | DEATH (Cho | eck only one) 6 Other (S 28d. DESCP 28f. LOCATI City or to the cause time, date an | PERFORM YES 2 Sipecity) IBE HOW IN ON (Street are) ON (Street are) (a) end mans | WED? NO JURY OC AND AND AND AND AND AND AND AN | r or Rural Ro | AMALABLE PRIOR TO COMPLETION OF CAUSIOF DEATH? 1 YES 2 NO Dute Number, and manner as stated | |
| that initiated events resulting in death) LAS PART II. Other signification of the control of th | ont condition Color OUS † OMEDICAL Pending investigation Could not be determined TIFYING PHYS ICAL EXAMINE | HOSPITAL: 1 Inpetient 2 28e. PLACE O building. | ER/Outpatient INJURY ay, Year) FINJURY — A1 h etc. (Specify) | 3 DOA 26b. Tiff | 26. OTHER: 4 Nursing H 4E OF 28c. I JURY M 1 [street, factory, of | PLACE OF COME 5 R NJURY AT WORK? YES 2 Titles and place in death occur | DEATH (Christian NO NO NO NO NO NO NO NO NO NO NO NO NO | eck only one) 6 Other (S 28d. DESCP 28f. LOCATI City or to the cause time, date an | PERFORM YES 2 Sipecity) IBE HOW IN ON (Street are) ON (Street are) (a) end mans | WED? NO JURY OC AND AND AND AND AND AND AND AN | r or Rural Ro | AMALABLE PRIOR TO COMPLETION OF CAUS: OF DEATH? 1 YES 2 NO | |
| that Initiated events resulting in death) LAS PART II. Other signification of the control of th | ont conditions of the conditio | HOSPITAL: 1 Inpatient 2 28e. DATE OF building. SICIAN: To the beals of e | ER/Outpatient INJURY Any, Year) PINJURY — A1 h etc. (Specify) Try knowledge, d examination and/or | 3 DOA 26b. Tilk IN Porme, farm | 26. OTHER: 4 Nursing H 4E OF 28c. I JURY M 1 street, factory, of | PLACE OF COME 5 R NJURY AT WORK? YES 2 Titles and place in death occur | DEATH (Cho | eck only one) 6 Other (S 28d. DESCP 28f. LOCATI City or to the cause time, date an | PERFORM YES 2 Sipecity) IBE HOW IN ON (Street are) ON (Street are) | WED? NO JURY OC AND AND AND AND AND AND AND AN | r or Rural Ro | AMALABLE PRIOR TO COMPLETION OF CAUSI OF DEATH? 1 YES 2 NO NO NUMBER OF CAUSI OF CAUSI OF CAUSI OF CAUSI OF CAUSI OF CAUSI OF CAUSI OF CAUSI OF CAUSI OF CAUSI OF CAUSI OF CAUSI OF CAUSI OF CAUSI OF CAUSI OF CAUSI OF CAUSI | |
| that initiated events resulting in death) LAS PART II, Other significe A TELLO S CLUBBLE 25. WAS CASE REFERRED T EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6 4 Homicide 29e. CERTIFIER (Check only one) 2 MED | Pending Investigation Could not be determined TIFYING PHYS PICAL EXAMINE F PERSON WITH | HOSPITAL: 1 Inpetient 2 28e. PLACE O building. SICIAN: To the best of error of the basis of error o | ER/Outpatient ENJURY — A1 h etc. (Specify) Try knowledge, d examination and/or | 3 DOA 26b. Tilk IN Porme, farm | 26. OTHER: 4 Nursing H 4E OF 28c. I JURY M 1 street, factory, of | PLACE OF COME 5 R NJURY AT WORK? YES 2 Titles and place in death occur | DEATH (Cho | eck only one) 6 Other (S 28d. DESCP 28f. LOCATI City or to the cause time, date an | PERFORM YES 2 Sipecity) IBE HOW IN ON (Street are) ON (Street are) | WED? NO JURY OC AND AND AND AND AND AND AND AN | r or Rural Ro | AMALABLE PRIOR TO COMPLETION OF CAUS OF DEATH! 1 YES 2 NO | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Nours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the functal director, page 5 should be detached for use as the burial-transit permit. be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. **BALTIMORE, MARYLAND 21215-0020** DIVISION OF VITAL RECORDS, P.O. BOX 68760,

3



| DIVISION OF VITAL RECORDS, P.O. BOX 68760 |
|---|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Fours after death. Page 6 may be retained by the hospital or attending |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the |
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| IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

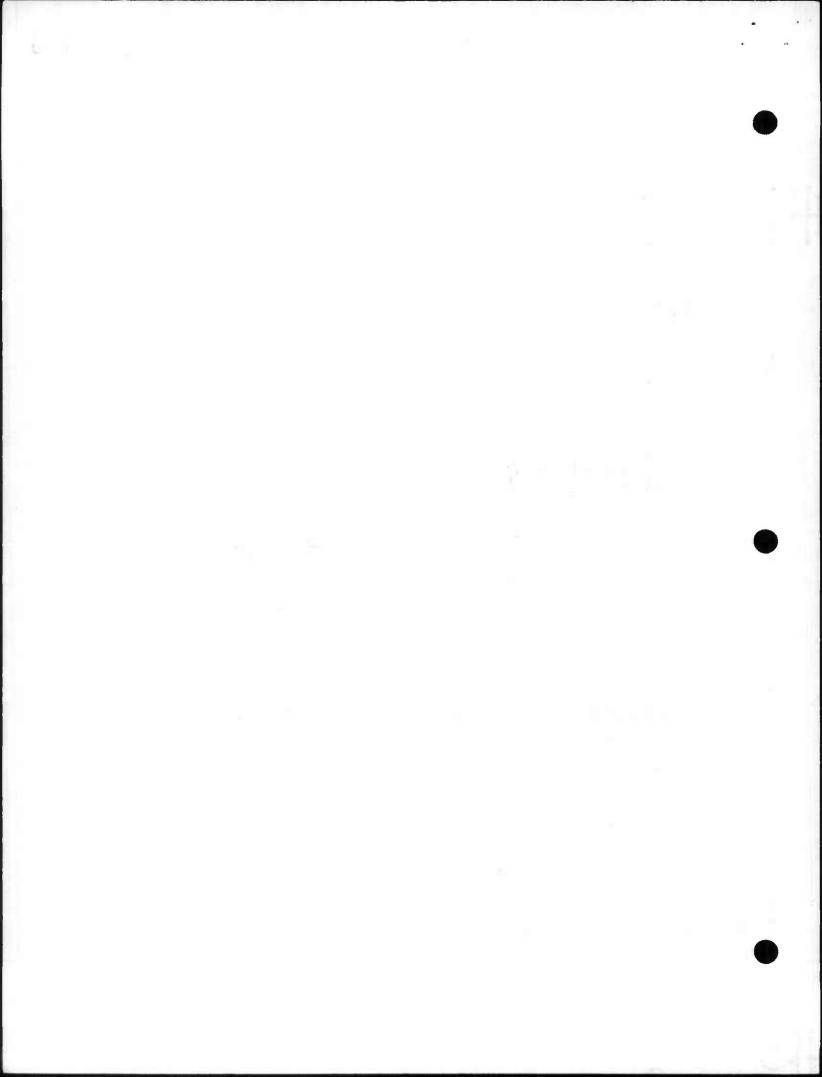
FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH

REG. NO.

| | REGISTRAR | | CERTIF | CATE (| OF DEATH | REC | G. NO. | | | |
|---------------|--|--|--------------------------------|---|--------------------------|---|---------------------|---|----------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | | 3. TIME OF DEATH | | |
| | Arthur Fletcher | | | | | MONTH O7 | 24 1 | 994 | 1420 M | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | 6. AGE (In | yrs. last birthday) | IF UNDER 1 YE | AR IF UNDER 24 HRS. | 7. DATE OF BIR | | _ | IPLACE (State or Foreign | |
| | 570 01 2040 11 M 2 | F 25 | YRS. | MONTHS DA | | (Month, Day, | Year) | Counti | ny) | |
| | 9e. FACILITY NAME (If not institution, give street and numb | / /3 | | | | 02 07 | | | INGTON, D.C. | |
| ~ | 38. PACIETY NAME (II NOT INSTITUTION, GIVE STREET and number | 91) | | | WN OR LOCATION OF D | | 9c. CO | UNTY OF D | EATH | |
| ō | Calvert Memorial Hospit | al | | PRINC | E FREDERIC | CK | 0 | alvei | rt | |
| DIRECTOR | 10a. STATE 10b. COUNTY | | 40.000 | | | | | | | |
| Ĕ | | 10c. G11 | , TOWN OR L | DCATION | | | | 10d. INSIDE CITY LIMITS? | | |
| | MARYLAND ST. MARY'S | | | <u> XINGTO</u> | N PARK | | | 1 TES 2 X NO | | |
| ₹ | 10e. STREET AND NUMBER | | | 10f. ZIP CODE | CODE 10g. CITIZE | | | WHAT COUNTRY? | | |
| FUNERAL | #5 ESPERANZA CIRCLE | | 20653 | | | IINI | TED | STATES | | |
| 5 | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AF FORCES? 1 X YES 2 Married 12. WAS DECEDENT EVER IN U.S. AF | | | | DECENDENT OF HISPAI | | olfy Yea or No- | E — American Indian. | | |
| | IE AEG V | | | I, specify Cuben, Mexica YES 2 X NO Specific | | Puarto Rican, etc.) Black, White, a Specify: | | | | |
| B | 3 Widowed 4 Divorced 1947 | | '" | The Rights opposit | , | | WHI | · | | |
| | 15. DECEDENT'S EDUCATION | 16a. DECEDENT'S | USUAL OCCU | PATION | OF BUSINESS/INDUSTRY | | | | | |
| ᇤ | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4) | (Give kind of w life. Do NOT us | rork done durin e retired.) | g most of working | | | | | | |
| ᆲ | 12 | MILITARY | / OFFI | CFR | DEE | ENSE | F | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | OIII | | ME (First, Middle, | | | | |
| | ARTHUR A. FLETCHER, SR. | | | | | | | | | |
| 띪 | 190. INFORMANT'S NAME (Type/Print) | | 1 | | | UMPACKE | | | | |
| 임 | 10 1/2 10/2 10/2 11/2 11/2 | | | | eet and Number or Rural | | | | | |
| | MIRIAM M. FLETCHER | | | | A CIRCLE, | | | | | |
| | 20e. METHOD OF DISPOSITION 1 □ Burlal 2 ☒ Cremetion 3 □ Removal from Sta | te come | LACE AND DATE O | F DISPOSITIO berolace) | N (Name of | OATE 2 | | OCATION — City or Town, Stata | | |
| | 4 Donation 5 Other (Specify) | M | ETROPOLI | | | | VIRGIN | IIA | | |
| | 21. SIGNATURE OF FUNERAL BERVICE LYMSE | > | | | E AND ADDRESS OF FA | | OME | | | |
| | MICHAEL P DIANUENO | מדווי | | | | NERAL HOME LEONARDTOWN, MARYLAND 20650 | | | | |
| \dashv | MICHAEL K. BLANKENS 23. PART I. Enter the diseases, or complication | | the death De- | P.C | BUX 279. | LEONAR | RDTOWN, | MARY | | |
| | shock, or heart feilure. List only on | e couse on eed | ch line. | or enter tha | mode or dying, suc | n es csrdiac oi | raspiratory a | rreat, | Approximate interval Between | |
| - 1 | IMMEDIATE CAUSE (Final | I | | . 1 | 1 | / | | | Onset and Death | |
| | disease or condition resulting in death) | FINOW | +=571 | ono/ | B(000 | ras | | | | |
| | OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| z | Conventially list and distance b. M. | son t | eric | (lon | ous 7h. | ron bo | 05-3 | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury CAUSE (DISEAUCE) | | | | | | | | | |
| <u>S</u> | cause. Enter UNDERLYING CAUSE (Disease or injury | مد رود | (5 | TT | to Flo | 100 | | | | |
| <u> </u> | that initiated events | JE TO (OR AS A C | CONSEQUENCE OF |): | | | | | | |
| H | resulting in death) LAST | | | | | | | | | |
| | PART ii Other significant conditions contribution | an to don'th had | | - th d | Man advantage of | D. A. L | | . 1 | | |
| DICAL | PERFORMED? AM | | | | | | | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | |
| ă | <u> </u> | | | | | 1 🗆 | YES 2 HO | | COMPLETION OF CAUSE OF DEATH? | |
| ME | | 1 YES 2 NO | | | | | | | | |
| ż | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES TO NO ID | | | | | | | | | |
| ₹ | 25. WAS CASE REFERRED TO MEDICAL | | | 2 | 8. PLACE OF DEATH (Ch | reck only one) | | | | |
| ဗ္ဗ | EXAMINER? 1 YES 2 NO 1 Investign | 28. PLACE OF DEATH (Check only one) | | | | | | | | |
| PHYSICIAN: | 27. MANNER-OF DEATH 28a. OA | TE OF INJURY | 28b. TIME | | INJURY AT | | HOW INJURY O | CCUREO | | |
| | 1 Natural 5 Pending | onth, Day, Year) | INJ | JRY | WORK? | | | | | |
| B | 2 Accident Investigation | ACE OF INJURY - | - At home form a | | | 204 LOCATION | (Canada and Atlanta | | | |
| | 3 Suicide 6 Could not be but | building, atc. (Specify) | | | | | | t and Number or Rural Route Number, e) | | |
| <u> </u> | | | | | | | | | | |
| 뢰 | (Check only CERTIFYING PHYSICIAN: To the b | | | | | | | | | |
| COMPLE | One) 2 MEDICAL EXAMINER: On the beel | a of examination | and/or investigation | n, in my opini | on, death occured at the | time, date end pl | ece, and due to | the couse(s | i) and manner as stated. | |
| U I | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUI | MBER | 29d. DA | TE SIGNEC | (Month, Day, Year) | |
| m | Marrie V Zumarralei M I | D 2 4 9 9 5 | | | | | | | | |
| 임 | | Wayne K. Zurowski, M.D. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | |
| | CALVERT MEDICAL ARTS BUILDING, PRINCE FREDERICK, MARYLAND | | | | | | | | | |
| | 31. DATE FILEO (Month, Day, Year) | | | | | | | | | |
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BALTIMORE, MARYLAND

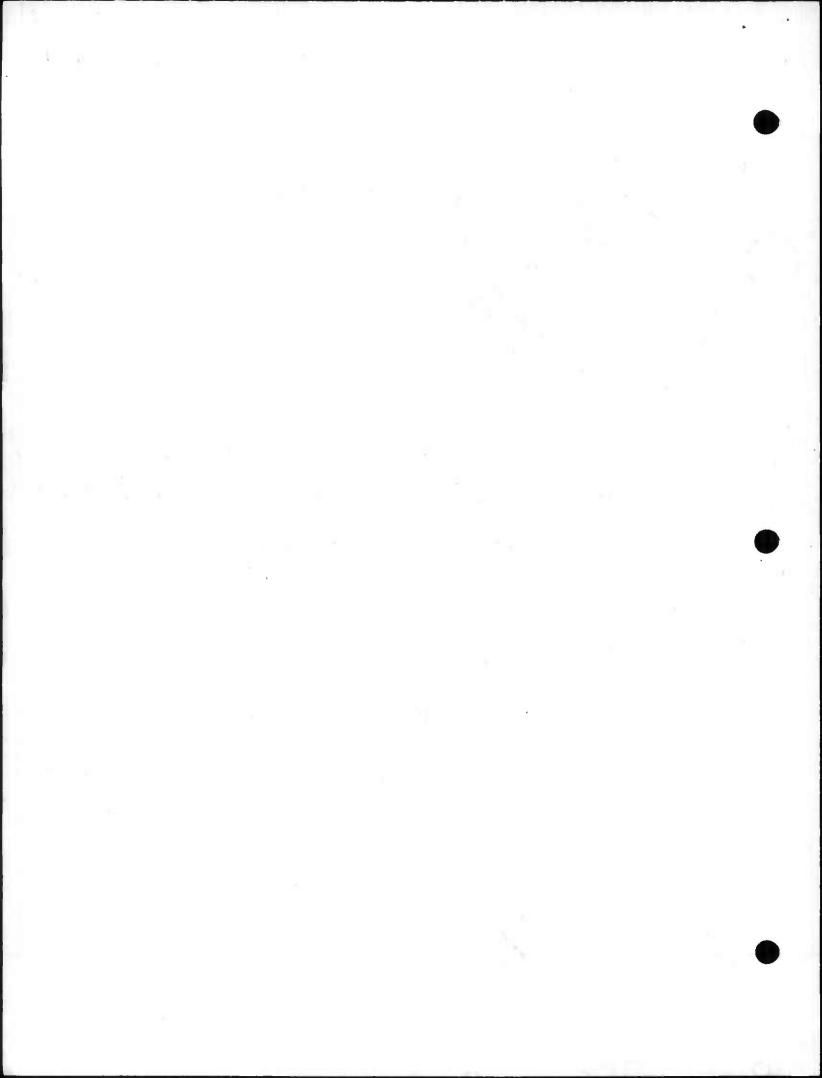
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1994

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATN Geoffrey 0148 August 12, 1994 Scot Fletcher 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DAYS Apr 29, Maryland HOURS 25 YRS. 1 X M 2 - F 1969 217-62-4877 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR 19 Windsor Drive St. Mary's Lexington Park 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 YES 2 NO Maryland St. Mary's Lexington Park FUNERAL 10e. STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? 401-D Spyglass Way 20653 U.S.A. 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—It yea, specify Cuban, Maxican, Puerto Rican, stc.) 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE - American Indian, Black, White, etc. FORCES? 1 YES 2 2 XINO 1 Never Married 2 Married 1 YES 2 NO Specify: ΒY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highes (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Company 4 years Engineer once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ Richard Fletcher Cheryl John Mae Kossuth BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Richard J. Fletcher 5100 Monticello Court, Waldorf, Maryland 20601 pe 20a. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata must 20s. METHOD OF DISPOSITION

1 Burlal 2 Corporation 3 Removal from State

4 Donation 5 Other (Specify) Metropolitan Crematory 8/13/94 Alexandria, Virginia examiner SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Mattingley-Gardiner Funeral Home, P.A. Mchael diner P.O. Box 270, Leonardtown, Maryland medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate hack, or heart fallure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Finel event, the disesse or condition_ resulting in death) DUE TO (OR AS A CONSEQUENCE OF): 110 traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 5 inlury. PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 24a. WAS AN AUTOPSY MEDICAL any 1 TYES 2 NO Shows 1 - YES 2 - 10 PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: VES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 X Residence 8 C Other (Specify) 6 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED
Driver lost control of vehicle marked. t Natural
2 Accident 5 Pending Investigation Aug 12, 1994 1:48 A 1 YES 2 NO BY After t left roadway 26s. PLACE OF INJURY — At home, term, street, factory, office building ste (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 3 Suicida HOSPITAL DR ATTEND FUNERAL DIRECTOR: A within 72 hours after d COMPLETED 8 Could not be 28 4 Homicide 19 Windsor Drive Lexington Park, Maryland Tem! 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and man TO THE FUNERAL D
TO THE FUNERAL D
be filed within 72 h
IMPORTANT: If it (Check only one) 2 MEDICAL EXAMINER: On the beals of examin 296. SIGNATURE AND TITLE OF CERTIFIES 29d. DATE SIGNED-(Month, Day, Year) 29c. LICENSE NUMBER BE 38. HAME WID ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James C. Boyd, M.D. Leonardtown, Maryland 20650 32. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year)



FOR

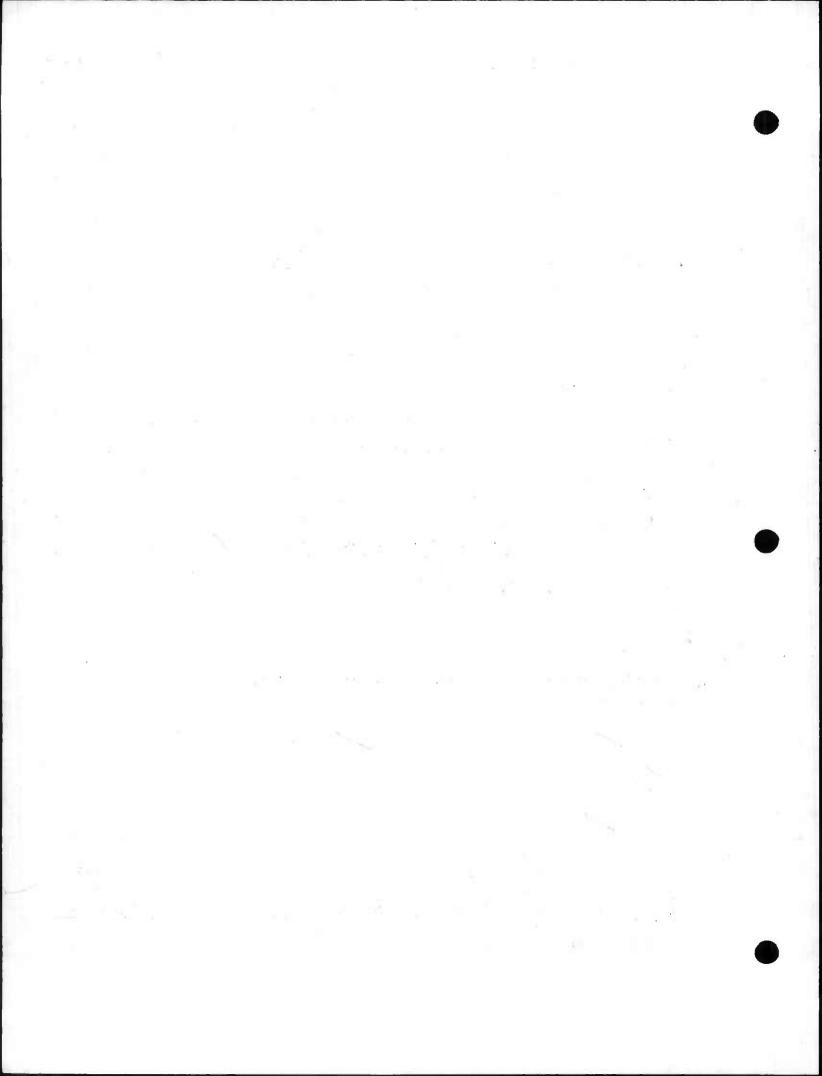
Helen Shafer Fisher
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1 - STATE REGISTRAR | · · · · · · · · · · · · · · · · · · · | CE | | | 96. CITY, TOWN OR LOCATION OF DEATH Williamsport TOWN OR LOCATION Liamsport 106. INSIDE CITY LIMITS? 1 YES 2 K NO 107. ZIP CODE 21795 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, appetly Cuben, Mexicen, Puerio Ricen, etc.) 1 YES 2 K NO 14. RACE — American Indian, Black, White, etc. Specify: White SUAL OCCUPATION SUAL OCCUPATION COPPER Our Ourling most of working refred.) COPPER Our Our Found Number or Rural Route Number, City or Town, Stete, Zip Code) TOWN OR LOCATION — City or Town, Stete, Zip Code) Proceding Avenue Williamsport, Maryland 21795 EDISPOSITION (Name of Puerior Route) Copper Our Our Number of Puerior Route Number, City or Town, Stete, Zip Code) Proceding Avenue Williamsport, Maryland 21795 EDISPOSITION (Name of Puerior Route) Copper Our Our Our Our Our Our Our Our Our Ou | | | | | | | |
|--|--|---------------------------------------|----------------------------------|----------------------------|--------------------------------------|--|------------|-------------------------------|---------------------------------------|---|---------------|--|--|
| | t. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH | | | | | | | | | 3. TIME OF DEATH | | | |
| | HELEN S | FISHER | | | | | | | | | 12:01 AM | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. | AGE (in yrs. lest | birthday) | birthday) IF UNDER 1 YEAR IF UNDER : | | | . 7. D | 7. DATE OF BIRTH | | 8. BIRTH | PLACE (State or Foreign | |
| | 214-10-3174 | t 🗌 M 2 💢 F | 88 | YRS. | MONTHS DA | NYS HO | URS MIN. | M | ay 16, | 1906 | Mary | land | |
| | 9a. FACILITY NAME (If not institution, give street and number) | | | 9b. CITY, TOWN OR LOCATION | | | DCATION OF | DEATH | | | | | |
| R | Homewood Retireme | Williamsport Washing | | | | | ton | | | | | | |
| ן ק | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT | | | | | | | | | | | | |
| 2 | | | | | toc. CITY, TOWN OR LOCATION | | | | | 10d. | | | |
| 5 | Maryland Washington | | | | | | | | | | | | |
| RA | A state of the sta | | | | | | | | | | WHAT COUNTRY? | | |
| TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION TO BE COMPLETED BY FUNERAL DIRECTOR | 16505 Virginia Avenue 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U. | | | | | | | | | | | | |
| | t Never Married 2 Married | FORGERS A VEG | | | If yes, specify Cuban, Mexicen, | | | | | n, Puerio Rican, etc.) Black, White, etc. | | | |
| | ts. DECEDENT'S EDI | 18a, DEC | 18e. DECEDENT'S USUAL OCCUPATION | | | | | 165 KIND OF BUSINESS/INDUSTRY | | | WIIICE | | |
| | (Specify only highest grad | completed) College (t-4 or 5+) | (Giv | e kind of v Do NOT us | vork done durir se retired.) | g most of | working | | 1001111110 | 00 | | | |
| 뒫 | 12 | | | | bookkeeper | | | | | General Acceptance Corp. | | | |
| 8 | t7. FATHER'S NAME (First, Middle, Last) | | | | ta. MOTHER'S NA | | | | ME (First, Middle, Maiden Surname) | | | | |
| | Simon Leslie Shaf | er | | | | | | | | | _ | | |
| | | | | | | | | | | | | 1 04705 | |
| | Gertrude S. Brown 1650 | | | | VII GITTE TWENTE | | | | | | | | |
| | 20a. METHOD OF DISPOSITION 1 Neurisl 2 Cremation 3 Ren | novel from State | | | | | | ļ | | | | | |
| | | | | | | | | | | | | | |
| | July We Was I | | | | Gerald N. Min Funeral Home | | | | Hagerstown, Maryland | | | | |
| - | 23 PART I Enter the diseases of | 11 muc | <u> </u> | | | | | | | | | Maryland | |
| | 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, abook, or heart failure. List only one cause on each lina. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. OSSESSE DEPT-E WARP AIRCRAFT. | | | | | | | | | | | | |
| NO | DUE TO (OR AS A CONDICOUENCE/OF): Sequentially list conditions b. | | | | | | | | | | | | |
| Ä | DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | | |
| E | CAUSE (Disease or injury that initiated events | DUE TO (OF | AS A CONSEO | UENCE OF | F): | | | | | | | - | |
| H | resulting in death) LAST | | | | | | | | | | | | |
| - 11 | PART II. Other algnificant condition | na contributing to de | ath but not re | eulting | in the under | lulna car | use alven | In Part | 1 24- MAG | AN AUTOPSY | 1 045 | WEST AUTOROV ENIDAGO | |
| 8 | SVinto AV | :156M | 4- | 60 | Wins | -10 | | - Tall | PERF | ORMED? | 240. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE | |
| | 1 15/0- 60 | Trule | | W | Con C | 10 | ETIC | - | t 🗌 YES | 2 NO | | OF DEATH? | |
| | hyper sico | | | | | | | | | | | | |
| Z | 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) | | | | | | | | | | | | |
| Sic | EXAMINER? | HOSPITAL: | t/Outpetient 3 (| DOA | OTHER: | | | | Other (Specify) | | | | |
| Ě | 27. MANNER OF DEATH | 28a. DATE OF INJ (Month, Day, | | 28b. TIM | E OF 280 | . INJURY | | _ | . DESCRIBE HOV | V INJURY OC | CORED | | |
| | t Accident 5 Pending Investigation | | (Monn, Day, 16ar) | | | M t YES 2 NO | | | | | | | |
| - 14 | 3 Suicide 8 Could not be 4 Homicide detarmined | 28a. PLACE OF IN building, etc. | JURY — At hom (Specify) | ne, farm, i | street, factory, | offica | | 281. | LOCATION (Street City or Town, Sta | et and Numbe te) | er or Rural F | loute Number, | |
| | 29a. CERTIFIER DEPTIEVING SUNCIONAL TO AN AND AND AND AND AND AND AND AND AND | | | | | | | | | | | | |
| ME | CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) end manner as stated. Check only one) 2 MEDICAL EXAMINES: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. | | | | | | | | | | | | |
| | 29b. SIGNATURE AND TITLE OF CENTRES (Month, Day, Year) | | | | | | | | | | | | |
| - 11 | 11111 | | | | | D26806 \ 8/2755 | | | | | | | |
| = | 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type Aprint) HID-VLIAD 747 No CHOM AND HIS ACTION AND H | | | | | | | | | | | | |
| | 3t. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S | SIGNATURE | | | - | O'N | | n - 1 | | | 1 | |
| | AUG 24 1994 Juli Danison Russe | | | | | | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the Hospital or attending physician or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trafish be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760



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1994

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31. DATE FILED (MONTH) Cay,

HOLZWOZTH

32. REGISTRAR'S SIGNATURE
John Denison Andre

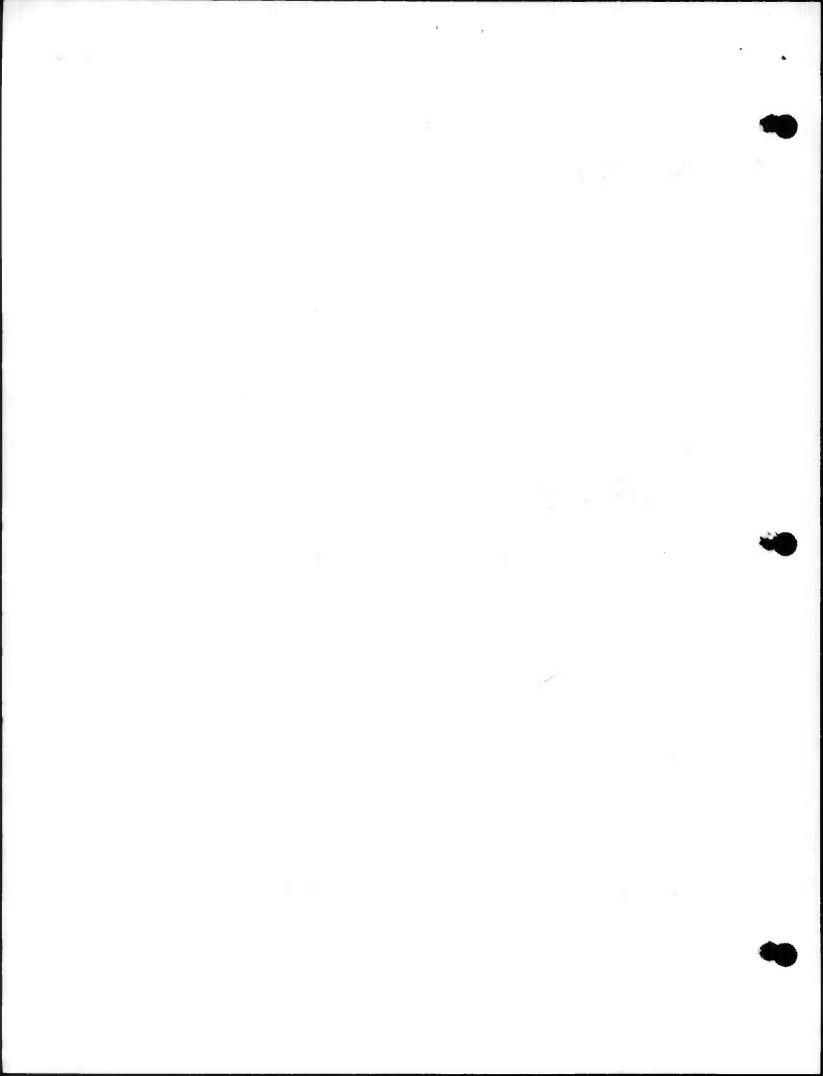
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a we's after death. Page 6 may be retained by the hos | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fined in by the funeral director, page 5 should be detach- | | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| | FOR 1 - STATE REGISTRAR | STATE OF MARYLAND C | / DEPARTMEN ERTIFICAT | T OF H E OF | EALTH AND I DEATH | MENTAL HYGIENI REG. NO. | E | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | OORIS ROPER GR | RIFFIN | | | 2. DATE OF DEATH DATE AUGUST 21, | 1994 | 3. TIME OF DEATH 1700 M | | |
| | 4. SOCIAL SECURITY NUMBER 212-16-8636 | 5. SEX 6. AGE (In yrs. In 75 | YRS. IF UNDE | DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Morith, Day, Year) 5-22-19 | C | IRTHPLACE (State or Foreign ountry) ARYLAND | | |
| O.B. | 98. FACILITY NAME (If not institution, give str 711 LAUREL AVENUE | • | 1 | . The second | R LOCATION OF DE | ATH | 9c. COUNTY O | RCESTER | | |
| [[[| RESIDENCE OF DECEDENT 10a. STATE 10b., COUNTY | | 10c. CITY, TOWN | OR LOCAT | ION | | | 10d. INSIDE CITY | | |
| L DIRECTOR | MD. WORCE | STER | | N CIT | | | 44- 07777511 | 1 YES 2 NO OF WHAT COUNTRY? | | |
| FUNERAL | 711 LAUREL AVENUE | | | | 21842 | | | USA | | |
| ВУ | | | | | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) | Cation 16e, D (in the completed) 16e, D (in the completed) (in the completed) (in the complete depth of the co | ECEDENT'S USUAL (Give kind of work done le. Do NOT use retired.) FLORIST | during mo | DN st of working | 166. KIND OF BUS | A I L | яу | | |
| Š | 17. FATHER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S NA | ME (First, Middle, Malden | Surname) | | | |
| BEC | WILLIAM ROPER | | | | | OTTINGER | | | | |
| 10 | II 19a INFORMANT'S NAME ("Vno/Print") I 19b MAR ING ADDRESS (Sheet and Number of Rural Boute Number City or Town State Zin Code) | | | | | | | | | |
| | 20a_METHOD OF DISPOSITION 20b. PLACE OF DISPOSITION (Name of cometery, crematory or other place) 20c. LOCATION — City or Town, State | | | | | | | | | |
| | 4 Donation 5 Other (Specify) LOUDEN PARK CEMETERY BALTIMORE, MD. 21. SIGNATURE OF FUNETIAL SERVICE LICENSEE | | | | | | | | | |
| | ULLRICH FUNERAL HOME BERLIN, MD. | | | | | | | | | |
| | 23. PART I. Enter the diseases, or co | omplications that caused the d List only one cause on each lin | | r the mo | de of dying, suc | h es cardiec or respi | ratory srrest, | Approximats Interval Batween | | |
| | iMMEDIATE CAUSE (Finel disease or condition resulting in death) s. PANCEETTC CARCINOMA DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| NOIL | Sequentielly list conditions, if sny, leading to immediate | DUE TO (OR AS A CONSI | EQUENCE OF): | | | | | | | |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente | DUE TO (OR AS A CONSI | EOUENCE OF): | | | | | | | |
| | resulting in death) LAST | 1 | | | | | | | | |
| انا | PART II. Other significant conditions | e contributing to deeth but not | resulting in the | indertyln | g cause given in | Part I. 24a. WAS AN | | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | | |
| MEDICA | | | | | | 1 YES 2 | X NO | COMPLETION OF CAUSE OF DEATH? | | |
| | | | | | | - | | 1 YES 2 NO | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: | | | | | | | | | |
| Sic | EXAMINER? | HOSPITAL: 1 Inpatient 2 ER/Outpatient | 3 DOA 4 N | | ne 5 Residence | 6 Other (Specify) | | | | |
| у РНУ | 27. MANNER OF DEATH 1. Netural 5 Pending Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | | URY AT ORK? YES 2 NO | 28d. DEŞCRIBE HOW I | NJURY OCCURE | ED | | |
| TED BY | 2 Accident Investigation 3 Suicide 8 Could not be datarmined | 28e. PLACE OF INJURY — At a building, etc. (Specify) | home, farm, street, fe | ctory, offic | • | 281. LOCATION (Street City or Town, State) | | Rural Route Number, | | |
| COMPLET | (Orlock Orly) | CIAN: To the best of my knowledge, on the basis of examination and/o | | | | | | nuse(a) and manner as stated. | | |
| ш | 296. SIGNATURE AND TITLE OF CERTIFIER | 14/ // 2/ | . 4 | | 29c. LICENSE NU | | 1 | GNED (Month, Day, Year) | | |
| 0 8 | Dorothy C. A | Jogworth M. | id, | | 206 | 241 | 18- | -21-94 | | |

SNOW ST.

203

SUON HILL, ND. 21863



TO BE COMPLETED BY FUNERAL DIRECTOR

| DAL HMORE, MARTLAND | rs after death. Page 6 may be retained by the hosp | T by the funeral director, page 5 should be detache removal. | dical examiner must be notified at once. |
|--|---|---|--|
| STATE OF STA | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filed within 72 hours after death with the State Debt, of Heath and Mental Hyolene brior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

5

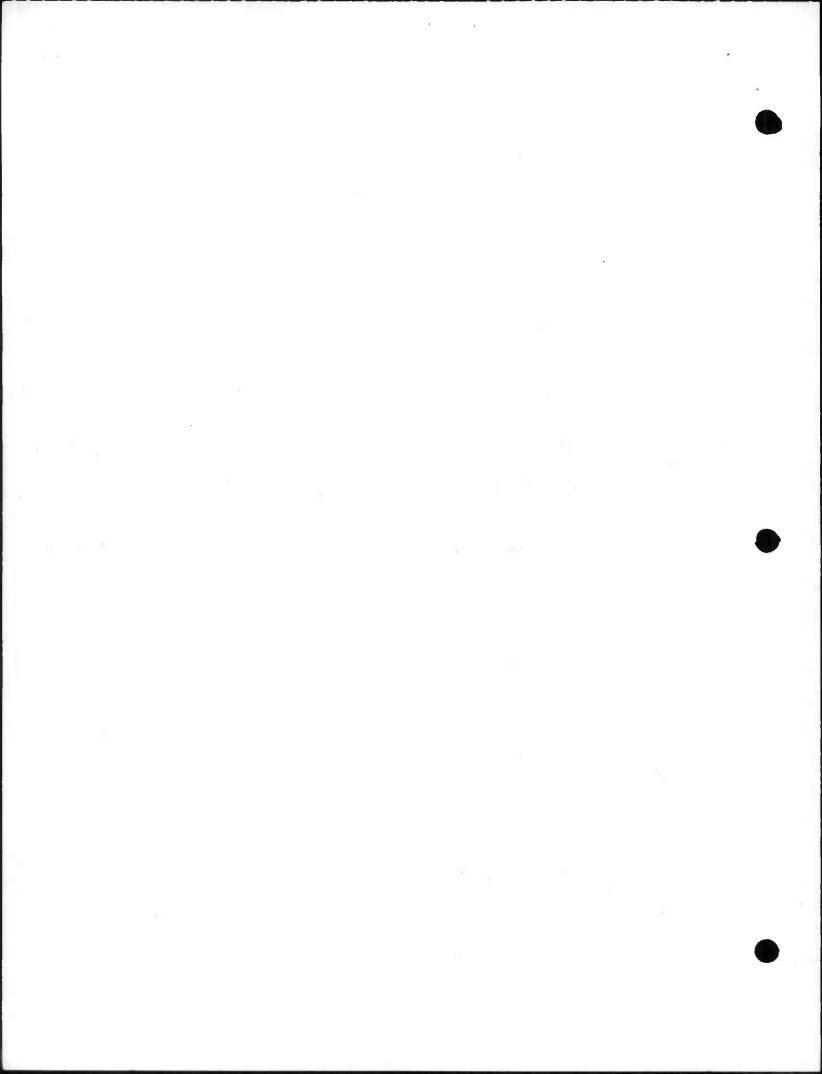
31, DATE FILED (Month, Day,

AUG

2 4

| | | | | | | | | | | | 2 | -4 | |
|----|---|---------------------------|------------|-----------------------|--------------|--------------------|--------------|------------|------------------|------------------------------------|-----------------|---------------|---|
| | FOR 1 - STATE REGISTRAR | STATE OF I | MARYL | AND / DEPA Certi | | | | | MENTA | L HYGIEN REG. NO | E | | |
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE | OF DEATH | | VEAD | 3. TIME OF DEATH |
| | \V | /ILLIAM | | GI | LLY | | | | | SUST 22 | $^{\circ}$, 19 | 994 | 1830 N |
| ľ | 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (| 'in yrs. last birthda | / | ER 1 YEAR | IF UNDER | | 7. DATE | OF BIRTN | | 8. BIRTH | IPLACE (State or Foreign |
| ì | 196-32-7531 | 1 M 2 - F | 5 | 2 YRS. | MONTH | DAYS | HOURS | MIN. | Q- | 71, Day, Year) | | Count | Ã. |
| Ì | 9a. FACILITY NAME (If not institution, give a | reet and number) | | - | 9b. Cf | TY, TOWN O | R LOCATI | ON OF DE | | <u> </u> | 9c. CO | UNTY OF D | |
| į | ATLANTIC GENERAL | HOSPITA | .1 | | l B | ERLIN | 1 | | | | Wo | RCES | TER |
| ł | RESIDENCE OF DECEDENT | 71001 | | | | | | | | | 110 | NOL 3 | TEN |
| | 10a. STATE 10b. COUNTY | | | | | OR LOCAT | ION | | | | | | 10d. INSIDE CITY LIMITS? |
| Ì | PA. LEH | HIGH | | LA | TASA | UQUA | | | | | | | 1 YES 2 NO |
| | 10e. STREET AND NUMBER | | | | | 101 | ZIP COD | E | | | 10g. CI | TIZEN OF Y | WHAT COUNTRY? |
| | 137 POPLAR STRE | ET | | | | | 180 | 132 | | | US | A | |
| | 11. MARITAL STATUS | 12. WAS DECEDEN | Ţ ĘYER II | U.S. ARMED | 1: | 3. WAS DEC | | | IIC ORIGII | N? (Specify Yes | | 1 | E — American Indian, |
| ۱ | 1 Never Married 2 Merried | FORCES? 1 | | | | If yea, sp | 2 NO | n, Mexica | n, Puarto | Rican, etc.) | | Spec | k, White, etc. |
| ı | 3 Widowed 4 Divorced | | | | - | | 2 110 | Specify | ,. | | | Spec | WHITE |
| Ì | 15. DECEDENT'S EDUC (Specify only highest grade | CATION | | 16a. DECEDENT | | | | | 168 | . KIND OF BUS | SINESS/IN | DUSTRY | |
| ١ | Elementary/Secondary (0-12) | College (1-4 or 5 | | life. Do NOT | work don | e during mo !.) | st of workir | ng | | | | | |
| ı | 12 | | <u> </u> | MA | INTA | INENC | F | | | FLOOR | TMG | | |
| ı | 17. FATHER'S NAME (First, Middle, Last) | | | | .,,,,, | 1112110 | | NER'S NAI | ME (First, | Middle, Malden | | | |
| ı | UNKNOWN | | | | | | 11 | NKNO | WN | | | | |
| ı | 19a. INFORMANT'S NAME (Type/Print) | | | 19b, MAILI | IG ADDRE | SS (Street a | | | | ber, City or Tow | n State 7 | in Code) | |
| ı | CAROLE GILLY | | | 137 | POPL | AR ST | . 0 | ATAS | AUQU | A, PA. | | 032 | |
| i | TO METHOD OF DISCOURAGE | | 700 | PLACE AND DAT | _ | | | | DAT | _ | | Ott Y- | |
| ı | 1 Burlei 2 Cremation 3 Females 4 Donation 5 Other (Specify) | ovel from State | | erery, crematory of | | | me or | | DAT | 20c. LO | CATION - | - City or To | own, Stata |
| ł | 21. SIGNATURE OF FUNETIAL SEPURCE LIC | nust 1 1 | _ | CEDAR | | MEMO | | | | AL | LENT | UMN | PA. |
| ı | . 11/2/11/1 | 77/1:1 | | | | | | | | | | | |
| ı | MONDO U | | | | Įυ | LLRIC | H FU | NERA | L Ho | ME BE | RLIN | , MD | • |
| 1 | 23. PART I. Enter the diseases, or o | omplications the | t caused | the deeth. Do | not ent | er the mo | de of dy | ing, auch | h aa cen | dlac or respi | ratory as | rreat, | Approximate |
| I | ahock, or haart failure. | List Dnly Dna cat | se on a | ach lina. | | | | | | | | | Interval Between Onset and Death |
| ١ | disease or condition | ne | * 12 X | | | | | | | | | | 4 |
| l | reaulting in death) | DUE TO | (OR AS A | CONSEQUENCE | OFI: | | | | | | | | MANY YRS |
| | | | | | /- | | | | | | | | į |
| Ì | Sequentially list conditions, | DUE TO | (OR AS A | CONSEQUENCE | on: | | | | | | | | |
| l | If any, laading to immediata cause. Enter UNDERLYING | | | | | | | | | | | | į |
| I | CAUSE (Disease or Injury that initiated events | DUE TO | (OR AS A | CONSEQUENCE | OFI: | | | | | | | | |
| ı | reaulting in death) LAST | | | | - , , | | | | | | | | j |
| l | | 1 | | | | | | | | | | | |
| | PART II. Other significant condition | a contributing to | death b | ut not reaultin | In tha | underlying | cause (| givan in i | Part I. | 24a. WAS AN | | 24b | WERE AUTOPSY FINDINGS |
| ľ | | | | | | | | | | PERFOR | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| I | | | | | | | | | | 1 1123 2 | DEC. NO | | OF DEATN? |
| | DID TOBACCO USE CONTI | PIRLITE TO CA | LISE O | E DEATH Y | /EC 🖂 | NO E | LINC | ERTAIN | | | | - 1 | 1 YES 2 NO |
| | 25. WAS CASE REFERRED TO MEDICAL | UDOIL TO CA | | 28. PLACE OF DE | | | OINC | LKIAII | ٠ L | | | | |
| ı | EXAMINER? | HOSPITAL: | | | ОТН | ER: | | | | | | | |
| | t YEYES 2 NO 27. MANNER OF DEATH | 1 Inpatient 2 | | | | uraing Hom | | sidenca | | | M ALABERT S | | |
| | 1 Netural 5 Pending | (Month, E | | 260. T | ME OF | | RK? | , l | 28d. DE: | SCRIBE NOW I | NJURY OC | CURED | |
| | 2 Accident Investigation | | | | М | | 'ES 2 | NO | | | | | |
| | 3 Suicide 6 Could not be 4 Nomicide determined | 28a. PLACE C building, | etc. (Spec | — At home, farm | , street, fa | ctory, office | | | 28f. LOC City | ATION (Street a or Town, State) | ind Numbe | er or Rural I | Route Number, |
| | | | | | | | | | | | | | |
| ۱ľ | 20a CERTIFIER | | | | | | | | | | - | | |

29c. LIÇENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 8-23-94 30. NAME AND ADDRESS OF PERSON WHO COMPLETED 203 SNOW STI



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E.W. Cole III, M.J. 31. DATE FILED (Month, Day, Year) 2 8 1994

| | | FOR 1 - STATE REGISTRAR | STATE OF MA | | DEPAR ERTIF | | | | | MENTAL | | E | -7 - | |
|-----|---|--|--|---|-----------------|-------------|-------------|--------------------------|-------------------------------------|--------------|------------------------------------|------------------|------------------------------------|--|
| r | | DECEDENT'S NAME (First, Middle, Last) Anne Satterly | Houston | Green | | ICAT | <u>L OF</u> | DEA | <u> </u> | | OF DEATH | [*] 994 | YEAR 3 | . TIME OF DEATH |
| | 0 | 4. SOCIAL SECURITY NUMBER 131-38-5344 | | TOTAL | | | | | _ | 7. DATE | OF BIRTH 19: | | 6. BIRTHPL Country) New York | ACE (State or Foreign |
| | | 9a. FACILITY NAME (If not institution, give st | | | | 9h CIT | V TOWN (| OR LOCATI | ION OF DE | | 15, 17. | | | |
| | | | | | | | | | | | | | | |
| | DIRECTOR | 10e. STATE 10b. COUNTY | No. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? | | | | | | | | | | | |
| | | 10e. STREET AND NUMBER | mary s | | 041 | | | f, ZIP COD | E | | | 10g, CIT | | AT COUNTRY? |
| | FUNERAL | 36 Holly Hill Lan | | | | | | 2061 | | | | U | S.A. | |
| | B | 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT 8 FORCES? 1 IF YES, GIVE WAR | YES 2 X | | | If yes, sp | ecity Cubi | OF HISPAN nn, Maxicai Specify | n, Puerto P | ? (Specify Yes tican, atc.) | or No | 14. RACE - Black, \ Specify: | - American Indian, White, atc. White |
| | | 15. DECEDENT'S EDUC (Specify only highest grade | | | CEDENT'S | | | | | 16b. | KIND OF BUS | SINESS/INC | DUSTRY | |
| | COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. | sic T | e retired.) | | IST OF WORK | ng | Pu | blic S | Schoo | ls | |
| | Š | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 16, MOT | HER'S NAI | ME (First, N | fiddle, Malden | Surname) | | |
| | BE | Robert Norman H | louston | | | | | 1 | Virgi | inia | Tuthi: | 11 | | |
| | | 19a. INFORMANT'S NAME (Type/Print) | | 191 | b. MAILING | ADDRES | S (Street a | and Numbe | r or Rural F | Route Numb | er, City or Tow | n, State, Zip | Code) | |
| | F | Peter David Green | 1 | | 36 Hc | 11y | Hil | l Laı | ne, (| Calif | ornia | , Mar | yland | 20619 |
| | | 20s. METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other piece) Trinity Church Cemetery 7—26—94 St. Mary's City, Maryland | | | | | | | | | | | | |
| | 21. Source for our Funeral Strive Using Service of Facility Brinsfield Funeral Home, P.A. 22. NAME AND ADDRESS OF FACILITY Brinsfield Funeral Home, P.A. 59 N. Washington St., Leonardtown, MD 20650-0279 | | | | | | | | | | | | | |
| | | 23. PART i. Enter the diseases, or complications that of used the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart feliure. Liet only one ceuse on each line. Approximate interval Between | | | | | | | | | | | | |
| | | iMMEDIATE CAUSE (Finel disease or condition resulting in deeth) | . Metasta | | | | er | | | | | | | Onset and Death |
| | _ 1 | | 00 10 (0 | R AS A CONSEC | DUENCE OF | F): | | | | | | | | |
| | CERTIFICATION | Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING | DUE TO (O | R AS A CONSEC | DUENCE OF | F): | | | | | | | | |
| | TIFIC | CAUSE (Disease or injury that initieted evente resulting in death) LAST | DUE TO (O | R AS A CONSEC | DUENCE OF | F): | | | | | | | | |
| | | | 1 | | | | | | | | | | | |
| Η. | MEDICAL | PART ii. Other eignificant condition | s contributing to de | eth but not r | esulting (| In the u | nderiyin | g ceuse | given in | Part i. | PERFOR | MED? | Al | ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE |
| | 2 | | | | | | | | | - | 1 NES 2 | X NO | 0 | F DEATH? |
| | PHYSICIAN: M | DID TOBACCO USE C | ONTRIBUTE 1 | O CAUS | E OF | DEAT | | | NO | | | | | YES 2 NO |
| | 3 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHE | | LACE OF E | DEATH (Che | ock only one | 9) | | | |
| | 2 | 1 YES 2 NO 27. MANNER OF DEATH | 1 Inpetient 2 E | | | | | | asidence | 6 Other | | | | |
| | | 1 Natural 5 Pending | 28a. DATE OF IN (Month, Day, | Year) | 26b. TIM INJ | URY M | | IURY AT ORK? YES 2 | ¬ NO | 26d. DEŞ | CRIBE HOW II | NJURY OC | CURED | |
| 1 | ED BY | 2 Accident Investigation 3 Suicide 6 Could not be determined | 26e. PLACE OF I building, etc | NJURY — At ho | me, farm, s | street, fac | | | | 26f. LOCA | ATION (Street a or Town, State) | nd Number | or Rural Rou | te Number, |
| | 4 | 29a. CERTIFIER . W CERTIFYING PHYSIC | CIAN. To the best of | . Imanda t | -45 | 4 - 4 - 7 | | | | | | | | |
| | COMPLE | (Check only one) 1 CERTIFYING PHYSIC MEDICAL EXAMINE | | | | | | | | | | | | hotete es sennem br |
| | - 11 | 29b. SIGNATURE AND TITLE OF CERTIFIER | | enton William | | , | 1 | | | | | | | |
| 100 | 2 2 | EurCole | W | | | | | D16 | 354 | ISEK | | | | onth, Day, Year) , 1994 |
| 1 6 | _ 15 | | | - | | | | | _ | | | | | |

M.D., 900 Bestgate Road, Annapolis, Maryland 21401

82. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

OHMH-16 Rev 1/89

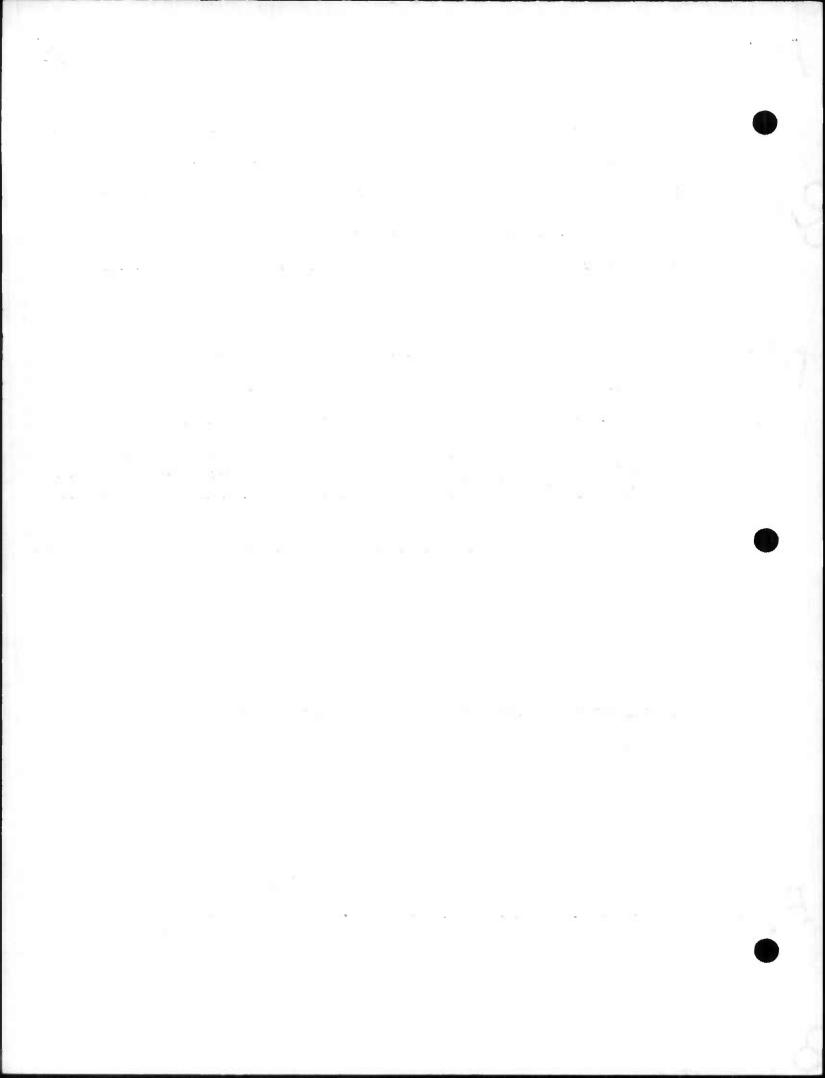
| - | 900 | 15.3 | |
|--|---|--|--|
| BALTIMORE, MARYLAND 21215-0020 | ours after death. Page 6 may be retained by the hospital or attending physician, | ed in by the funeral director, page 5 should be detached for use as the burgal-trains or removal. | medical examiner must be notified at once. |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-training to be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | - REGISTRAR | | CERTIF | ICATE OF | DEATH | REG. NO. | | |
|---------------|--|---|-------------------------------|--------------------------------|--|---|-----------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| 8 | Margaret Ann | Gast | | | | July 29, 1 | 994 | 4:00 p. M |
| Ĭ. | 4. SOCIAL SECURITY NUMBER | | E (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 0. 5 | BIRTHPLACE (State or Foreign |
| | 183-24-8245 | 1 □ M 2 😾 F 6 | 3 YRS. | MONTHS DAYS | HOURS MIN. | November 27. | 1930 Pe | Country) nnsylvania |
| | 9a. FACILITY NAME (If not institution, give a | itreet and number) | | 9b. CITY, TOWN | OR LOCATION OF O | | 9c. COUNTY | |
| DIRECTOR | 21 Rodo Beach | | | Scotla | ınd | | St. | Mary's |
| <u>ښ</u> | 10a. STATE 10b. COUNTY | Y | 10c. CIT | Y, TOWN OR LOCA | TION | | | 10d. INSIDE CITY |
| - 1 | | Mary's | Sc | otland | | | - 1 | 1 YES 2 X NO |
| FUNERAL | 100. STREET AND NUMBER 21 Rodo Beach | | | 10 | 20687 | | | OF WHAT COUNTRY? |
| ž I | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | IN U.S. ARMED | 13. WAS OF | | NIC ORIGIN? (Specify Yes | | S.A. RACE — American Indian. |
| B | 1 Never Married 2 Name Married 3 Widowed 4 Divorced | FORCES? 1 YES | S 2 NO | If yea, a | pecify Cuban, Maxica 3 2 X NO Specify | n, Puarto Rican, etc.) | 100 | Black, While, atc. Specify: White |
| 요 | 15. DECEDENT'S EDU (Specify only highest grade | CATION | 16a. DECEDENT'S | USUAL OCCUPATI | ON | 16b. KIND OF BUS | SINESS/INDUST | RY |
| <u> </u> | Elementary/Secondary (0-12) | College (1-4 or 5+) | IIII. Do NOT us | vork done during man retired.) | ost of working | | | |
| COMPLET | | 3 | Registe | red Nurs | e | Health | Care | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Maiden | Surname) | |
| BE | Albert D. Burgun | der | 105 11411 1110 | 10000000 (0) | | M. Aaron | | |
| 임 | William G. Gast | | | | | Route Number, City or Tow. aryland 20687 | | (n) |
| | 20a. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Rem | ovel from State | Db. PLACE AND DATE | OF DISPOSITION (N | ame of | OATE 20c. LO | CATION — City | or Town, State |
| | 4 Donation 5 Other (Specify) | Si | metery, crematory or o | s Cemetery | 7 | 8–1–94 Ri | dge, M | Maryland |
| 1 | Toller 11. | Durk | MODOE | | | Brinsfiel | | |
| \dashv | Edward N. Br 23. PART I. Entar the diseases, or o | | MOOO5 | | washington | St., Leonard | town, MD | 20650-0279 |
| ı | shock, or haart failure. | List only one cause on | aach lina. | or anter the th | Jua or dying, suc | n as cerdiac or respi | ratory errest, | interval Batween |
| | IMMEDIATE CAUSE (Final disease or condition | Waterstat | | . 1 7 | | | | Onset and Dasth |
| | resulting in death) | | ic Gastr | | reast Ca | ncer | | 26 months |
| _ | | h | | - | | | | İ |
| CERTIFICATION | Sequentisity list conditions, if any, leading to immediate | OUE TO (OR AS | A CONSEQUENCE O | 7 : | | | | |
| <u> </u> | CAUSE (Disease or Injury | С. | | | | | | |
| | that Initisted events resulting in dasth) LAST | DUE TO (OR AS | A CONSEQUENCE OF | F): | | | | |
| 5 | | d | | | | | | |
| - 118 | PART II. Other significant condition | is contributing to death | but not resulting | In the underlyin | g ceuse given in | Part I. 24s. WAS AN | | 24b. WERE AUTOPSY FINOINOS |
| DICAL | | | | | | PERFOR | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| <u> </u> | | | | | | | | OF DEATH? |
| | DID TOBACCO USE C | CONTRIBUTE TO | CAUSE OF | DEATH Y | ES NO | X | | |
| <u>₹</u> | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | LACE OF DEATH (Ch | eck only one) | | |
| PHYSICIAN: M | 1 TES 2 X NO | HOSPITAL: 1 Inpetient 2 ER/Ou | itpatlant 3 🗆 DOA | OTHER: 4 Nursing Hor | ne 5X Raaldenca | 6 Other (Specify) | | |
| | 27. MANNER OF DEATH | 26a. DATE OF INJURY (Month, Day, Year) | | | JURY AT | 26d. DESCRIBE HOW II | NJURY OCCURE | ED |
| <u> </u> | 1 Netural 5 Pending 2 Accident Investigation | | | | YES 2 NO | | | |
| - 111 | 3 Suicida 6 Could not be | 26a, PLACE OF INJUF building, atc. (Sp | RY — At home, farm, a pecify) | street, factory, offic | DB. | 26f. LOCATION (Street a City or Town, State) | and Number or R | lural Route Number, |
| | 4 Homicide detarmined | | | | | | | |
| COMPLEIED | | ICIAN: To the beat of my kno | wledge, death occurr | ed at the time, date | and place, and due | to the cause(a) and mar | iner as stated. | |
| 5 | one) 2 MEOICAL EXAMINE | R: On the basis of examinet | ion and/or investigation | n, in my opinion, | death occured at the | time, data and place, an | d dus to the ca | suse(a) and manner as stated. |
| H L | 29b. SIGNATURE AND TITLE OF CERTIFIED | A 1/~ | 5) | | 29c. LICENSE NUI | MBER | 29d. DATE SK | GNED (Month, Day, Year) |
| 2 | 1 | 110 | // | | D33123 | | ► Augu | ust 1, 1994 |
| - | 30. NAME AND ADDRESS OF PERSON WH | | | | | | | |
| | Jonathan D. Lowenth | | | Southern | Maryland | Blvd., Dunki | dk, MD 20 | 0754 |
| | 31. DATE FILED (Month, Day, Year) ALIC 0.9 1994 | 32. REGISTRAR'S SIG | | | | | | |

- 0



| (| Z | 1 | Divote C. J. Strong |
|---|----------------------------------|--|--|
| | BALTIMORE, MARYLAND 21215-0020 | YSICIAN: The law requires that the death certificate be executed writh hours after death. Page 6 may be retained by the hospital or attending physician; | s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trainsit permit. Present the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| | DF VITAL RECORDS, P.O. BOX 68760 | YSICIAN: The law requires that the death certificate be executed with | s certificate has been signed by the attending physician and completely filled in by the tith State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |

2

John W. Rosche.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) Frances 2. DATE OF DEATH Yeatman Goldsborough FRANCES GOLDS BOROUGH 1994 PM August 14:38 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 5. SEX 8. BIRTHPLACE (State or Foreign Country) DAYS HOURA 1 - M 2 - F 214-26-4585 July 15,1909 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF CEATH DIRECTOR St. Mary's Hospital Leonardtown St. Mary's 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland 1 YES 2 NO St. Mary's Lexington Park FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? Route 1, Box 162 20653 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—if yea, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: BY 3 Widowed 4 X Divorced White 16e. OECEOENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Bookbinder U.S. Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William Yeatman BE Mildred Cullison 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Pamela Groezinger 1233 Vine Street, Abiline, Texas 79602 ě 20a, METHOD OF DISPOSITION

1 A Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must The during 2 Cremation 3 Ramoval fro Michael's Ridge, Maryland examiner 22. NAME AND ADDRESS OF FACILITY Brinsfield Funeral Home Brinsfield MO0052 P.O. Box 279 Leonardtown Maryland medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fellure. List only one ceuse on each line. interval Between Onset and Death IMMEDIATE CAUSE (Finel the disease or condition MULITSYSTEM FAILURE
OUE TO (OR AS I CONSEQUENCE OF): event, resulting in death) ALLATIVE HEME SASTRECTIONS DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentielly list conditions, of Som sch, Pooly Defficularies, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated evente and Obstructing Ulceratas resulting in deeth) LAST PART II. Other algoriticent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PHYSICIAN: MEDICAL Ophoric Obstructor Pulman Asses PERFORMED? 1 TES 2 XNO 1 TES 2 NO 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL:
1 Inperient 2 ER/Outpetient 3 DOA OTHER:
4 | Nursing Home 5 | Residence 8 | Other (Specify) 10 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, L DIRECTOR: After this 2 hours after death with 1 tem 28 Is marked Natural 2 Accident 5 Pending 1 YES 2 NO BY Investigation 3 Sulcide 28e. PLACE OF INJURY — At home, farm, atreet, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED. 8 Could not be determined 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. COMPL TO THE FUNERAL DI
TO THE FUNERAL DI
DE filed within 72 ho
IMPORTANT: If Ite (Check only one) 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(e) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Allandrie

POBOX 186, Mechanismika, M. 20659

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MD, FACS.

REGISTRAN'S SIGNATURE

6031 11 15 11 2 21 21 1 10 445 Commercial and the state of the haraly my literahy Comment Regards May when the second of the second s

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| 1 - STATE REGISTRAR | 37.112 01 1 | | | | HEALTH AND F DEATH | | REG. NO. | | | |
|--|--|-----------------------------|--|------------------|--------------------------------------|-----------------|------------------------------------|------------------|--|--------------|
| 1. DECEDENT'S NAME (First, Middle, L | | E3.3 | 0 | | | MONTH | OF DEATH | AYY | 3. TIME OF DEA | тн |
| 4. SOCIAL SECURITY NUMBER | Mary | Ellen | Gearha | | | - | | 1994 | 3:00 | A |
| 214-36-0948 | 1 M 2 V F | 6. AGE (In yrs | | IF UNDER 1 YEAR | | (Month | of Birth , Day, Year) 31-192 | | BIRTHPLACE (State or F Country) | oreign |
| 9e. FACILITY NAME (If not institution, | Λ | 04 | | 9b. CITY, TOW | N OR LOCATION OF D | | 31-192 | 9c. COUNTY | | |
| Reeders Memor | ial Home | | | Boons | oro | | | Washi | ington | |
| 10a. STATE 10b. CO | | | 10c CITY, | town on Lo | eation oring, | | | | 10d, INSIDE CIT LIMITS? 1 YES 2 X | |
| 100. STREET AND NUMBER 12420 St. Pa | aul Road | | I | | 101. ZIP GODE 21722 | | | 10g. CITIZEN | OF WHAT COUNTRY? | , NO |
| 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Touroced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | YES 2 | ARMED | If yes, | Specify Cuben, Mexic ES 2 NO Spec | en, Puerto F | ? (Specify Yes | or No 14. | RACE American Ind Black, White, etc. Specify: White | |
| 15. DECEDENT'S (Specify only highest Elementary/Secondary (0-12) | | | DECEDENT'S U (Give kind of we life Do NOT use Sewl) | ork done during | most of working | 16b. | | e Fac | tories | |
| 17. FATHER'S NAME (First, Middle, Lass Mayberry I | Homer Hu | 11 | | | 18. MOTHER'S N | | | Sumeme) Gladh | ill | |
| 190. INFORMANT'S NAME (Type/Print) Edwin T. Sh: | irley | | 19b. MAILING / 12420 | | er end Number or Rurel Paul Rd. | | | | | 72 |
| 20a. METHOD OF DISPOSITION 1 Description 2 Cremetion 3 4 Donation 5 Other (Specify) | Removal from State | cametery, | CEAND DATE OF | er placa) | | DATE | Di | | or Town, State | |
| 21. SIGNATURE OF PUBLISH SERVICE | Medical Street | LPar | knean | Tho: | tery 8-2 AND ADDRESS OF F | aciuty inera | al Ho | me, I | | 0.0 |
| Sequentially list conditions, if any, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | b | OR AS A CON | SEQUENCE OF | : | | | | | | |
| PART II. Other significant cond | ditlons contributing to | death but n | ot resulting in | the underly | ing cause given in | n Part I. | 24a. WAS AN PERFOR | MED? | 24b. WERE AUTOPSY I AMRILABLE PRIOR COMPLETION OF OF DEATH? 1 YES 2 | R TO CAUS |
| | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICA EXAMINER? | HOSPITAL: | | | OTHER: | PLACE OF DEATH (C | | | | | |
| 1 VES 2 NO | 1 Inpatient 2 I | INJURY | 28b, TIME | | ome 8 - Residence | _ | | NJURY OCCUR | ED | |
| Netural 5 Pending | (Month, E | Day, Year) | INJU | RY | WORK? YES 2 NO | -50.000 | | 20 | | |
| 2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine | 25e, PLACE C | F INJURY — A etc. (Specify) | t home, ferm, st | reet, factory, o | Mice | | ATION (Street or Town, State) | | Rural Route Number, | |
| 000) | HYSICIAN: To the best of a | | | | | | | | ause(e) and manner se | state |
| 96. SIGNATURE AND TITLE OF CERT | | | | | 29c. LICENSE NU | | | | IGNED (Month, Day, Year | |
| R | Yuchu & | t m | | | D325 | 518 | | ▶ 8/ | 26/94 | |
| R. Guedenet | 100 Geet | se of Death | ane K | e edys | ville, | | | | | |
| 31. DATE FILED (Month, Day, Year) | | AR'S SIGNATUR | | -5 | | | | | | |
| | OL PIEGIO IN | A SIGNALION | Randall | | | | | | | |

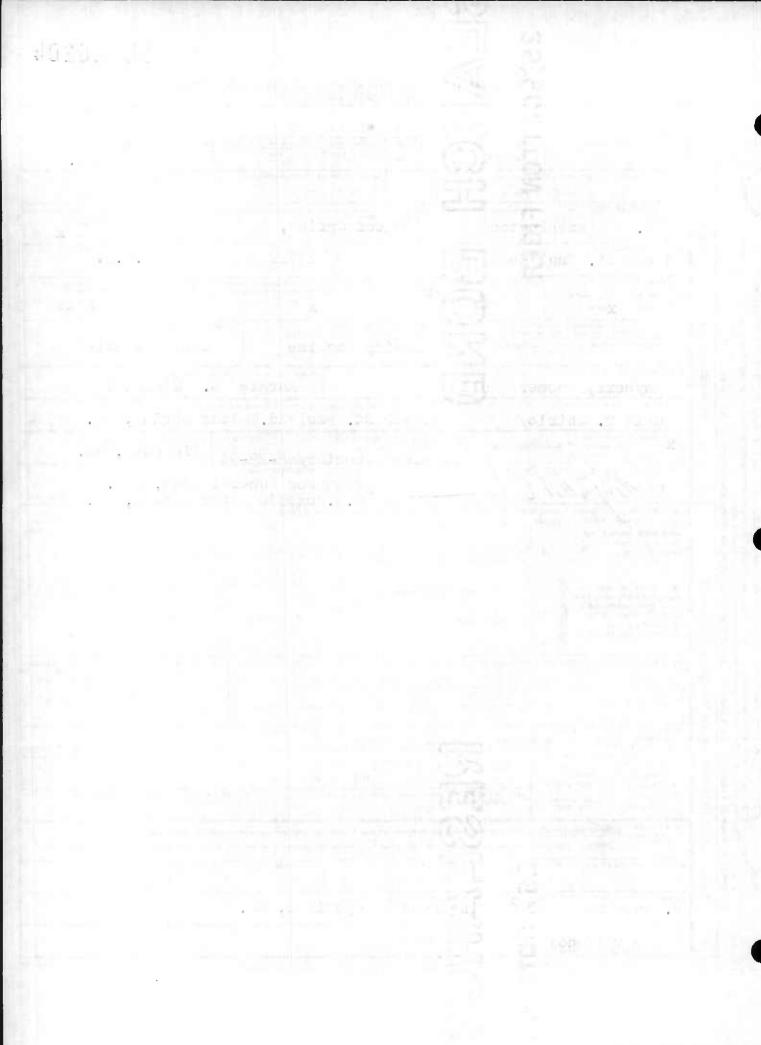


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Fours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filled within 72 hours after death with the State Degt, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

DHMH-18 Rev 1/89



| for death. Page 6 may be retained by the host the function of the function page 5 should be detached at examinar must be martified at once. | The state of the s |
|---|--|
| THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp to THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to fill with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTABLY If Item 28 is marked on item 23 shows any injury or other transmitted event the maritied examines must be maritied as once. | |

| DECEDENT'S NAME (First, Modes, Last) Edgar Maryin Grimm Edgar Maryin Hartin Funces 21 Med July 10 August Grim Francis Grimm Edgar Maryin Hartin Grimm Edgar Maryin Hartin Funces 21 Med July 10 August Grimm Edgar Maryin Hartin Funces 21 Med July 10 August Grimm Edgar Maryin Hartin Funces 21 Med July 10 August Grimm Edgar Maryin Hartin Funces 21 Med July 10 August Grimm Edgar Maryin Hartin Funces 21 Med July 10 August Grimm Edgar Maryin Hartin Funces 21 Med July 10 August Grimm Edgar Maryin Hartin Funces 21 Med July 10 August Grimm Edgar Maryin Hartin Funces 21 Med July 10 August Grimm Edgar Maryin Hartin Funces 21 Med July 10 August Grimm Edgar Maryin Hartin Funces 21 Med July 10 August Grimm Edgar Maryin Hartin Funces 21 Med July 10 August Grimm Edgar Maryin Hartin Funces 21 Med July 10 August Grimm Edgar Maryin Hartin Hartin Funces 21 Med July 10 August Grimm Edgar Maryin Hartin Funces 21 Med July 10 August Grimm Edgar Maryin Hartin Funces 21 Med July 10 August Grimm Edgar Maryin Hartin Funces 21 Med July 10 August Grimm Edgar Maryin Hartin Funces 21 August Grimm Edgar Maryin Hartin Funces 21 August Grimm Edgar Maryin Hartin F | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL I | HYGIENE REG. NO. | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|
| SOCIAL SECURITY NUMBER 212-14-6816 15 SEX 7 73 VIB. 15 SEX 7 73 VIB. 15 SEX 7 73 VIB. 15 SEX 7 73 VIB. 15 SEX 7 73 VIB. 15 SEX 7 73 VIB. 15 SEX 7 73 VIB. 15 SEX 7 73 VIB. 15 SEX 7 73 VIB. 15 SEX 7 73 VIB. 15 SEX 7 73 VIB. 15 SEX 7 73 VIB. 15 SEX 7 73 VIB. 16 SEX 7 73 VIB. 16 SEX 7 73 VIB. 16 SEX 7 73 VIB. 16 SEX 7 VIB. 17 SEX 7 VIB. 18 SEX 7 VIB. 19 SEX 7 VIB. 19 SEX 7 VIB. 19 SEX 7 VIB. 19 SEX 7 VIB. 19 SEX 7 VIB. 10 SEX 7 VI | | DEATH DAY YEAR 3. TIME OF OEATH | | | | | | | |
| Washington County Hospital Hagerstown Washington No. STREET OF PREEDERY 100, CITY, TOWN OR LOCATION 100, FREEDERY 100 | 212-14-6816 1 M 2 F 73 YRS. MONTHS DAYS HOURS MIN. | BIRTH 8. BIRTHPLACE (State or Foreign Quartry) Quartry) | | | | | | | |
| December | , | | | | | | | | |
| Secondary Seco | | 10d. INSIDE CITY LIMITS? 1 □ YES 2 X NO | | | | | | | |
| Secondary Seco | 2727 Harpers Ferry Road 21782 USA | | | | | | | | |
| See DECEDENT'S BUDGATION See DECEDENT'S USUAL OCCURRATION See DECEDENT'S USUAL OCCURRATION See Of Code during most of working also be NOT use ratered See Of Code during most of working also be NOT use ratered See Of Code during most of working also be NOT use ratered See Of Code during most of working also be NOT use ratered See Of Code during most of working also be NOT use ratered See Of Code during most of working also be NOT use ratered See Of Code during most of working also be NOT use ratered See Of Code See Of C | 3 Wildowed 4 Divorced World War II | en, etc.) Black, White, etc. Specify: | | | | | | | |
| The matrix and the matrix of t | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4 or 5 +) Machanic Machanic | NO OF BUSINESS/INDUSTRY | | | | | | | |
| 198. MALINA ADDRESS (Street and Number or Plant Route Number (Ply or Print) | Clyde McClellan Grimm Lottie May Ingram | | | | | | | | |
| 10 Burlet 2 Cremetton 3 Ramoval from State Sognitivo cogniti cognitivo cognitivo cognitivo cognitivo cognitivo cognitivo cogniti | 9 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, | | | | | | | | |
| 22. MAME AND ADDRESS OF FACILITY Eack les - Spencer Funeral Home Harpers Ferry, W 25425 23. PART L Enter the diseases, or complications that caused the dasth. Do not anter the mode of dying, such as cardiac or respiratory arrest, interest Battonic, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR | 1 M Buriel 2 Cremation 3 Removal from State | | | | | | | | |
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | 22. NAME AND ADDRESS OF FACILITY Eackles-Spencer Funeral Home Harpers Ferry, WV 25425 | | | | | | | | |
| disease or condition resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease or injury the intitisted everente resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Cause. Enter UNDERLYING CAUSE (Disease or injury the intitisted everente resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE | BANCHIAT CANON COLUMN ON CAUSE ON COLUMN ON CAUSE ON COLUMN CAUSE ON COLUMN CAUSE ON | Interval Between | | | | | | | |
| Sequentisity list conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONS | disease or condition a. Garalized athursclutic cardioviscular discuss | e with out | | | | | | | |
| CAUSE (Disease or injury that initiated evente resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): D | | Ton 3 days | | | | | | | |
| PART II. Other significant conditions contributing to death but not recuiting in the underlying cause given in Part I. All | If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events that initiated events that initiated events that initiated events the cause of the caus | | | | | | | | |
| AMABLE PRINT OF COMPLETION OF CAUSO OF DEATH YES 2 NO | resulting in deeth) LAST | | | | | | | | |
| Natural 5 Pending 2 Accident Investigation 28 PLACE OF IN HIPLY At home form stead forces of the control of t | PART II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. **Mathiable Prior to Completion of Cause OF DEATH?** 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | | | | |
| Natural 5 Pending 2 Accident Investigation 28 PLACE OF IN HIPLY At home form stead forces of the control of t | Z V WAS CASE REFERRED TO MEDICAL | 1 TES 2 NO | | | | | | | |
| Natural 5 Pending 2 Accident Investigation 28 PLACE OF IN HIPLY At home form stead forces of the control of t | EXAMINER? 1 YES 2 NO HOSPITAL: 1 Minpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (5 | ipecity) | | | | | | | |
| 286 PLACE OF IM HIPV — At home form elevat factors office | I 1 P Natural 5 Pendino | BE HOW INJURY OCCURED | | | | | | | |
| 29a. CERTIFIER (Check only one) 29 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and manner as stated. 20 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and manner as stated. | 286 PLACE OF INSIDY — At home form street feeton, effice | 1 286 PLACE OF INTIDY — At home form etenat factors office | | | | | | | |
| | 4 Homicide determined | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER; On the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and manner as stated. | | | | | | | |
| 296. SIGNATURE AND TITLE OF CERTIFIES 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Year) 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Year) | 4 Homicide determined determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, deta and place, end due to the cause of my knowledge of axamination end/or investigation, in my opinion, death occurred at the time, data and place of axamination end/or investigation, in my opinion, death occurred at the time, data and place of my knowledge of axamination end/or investigation, in my opinion, death occurred at the time, data and place of my knowledge of axamination end/or investigation, in my opinion, death occurred at the time, data and place of my knowledge of my know | | | | | | | | |

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

WD 747 North

MD 74

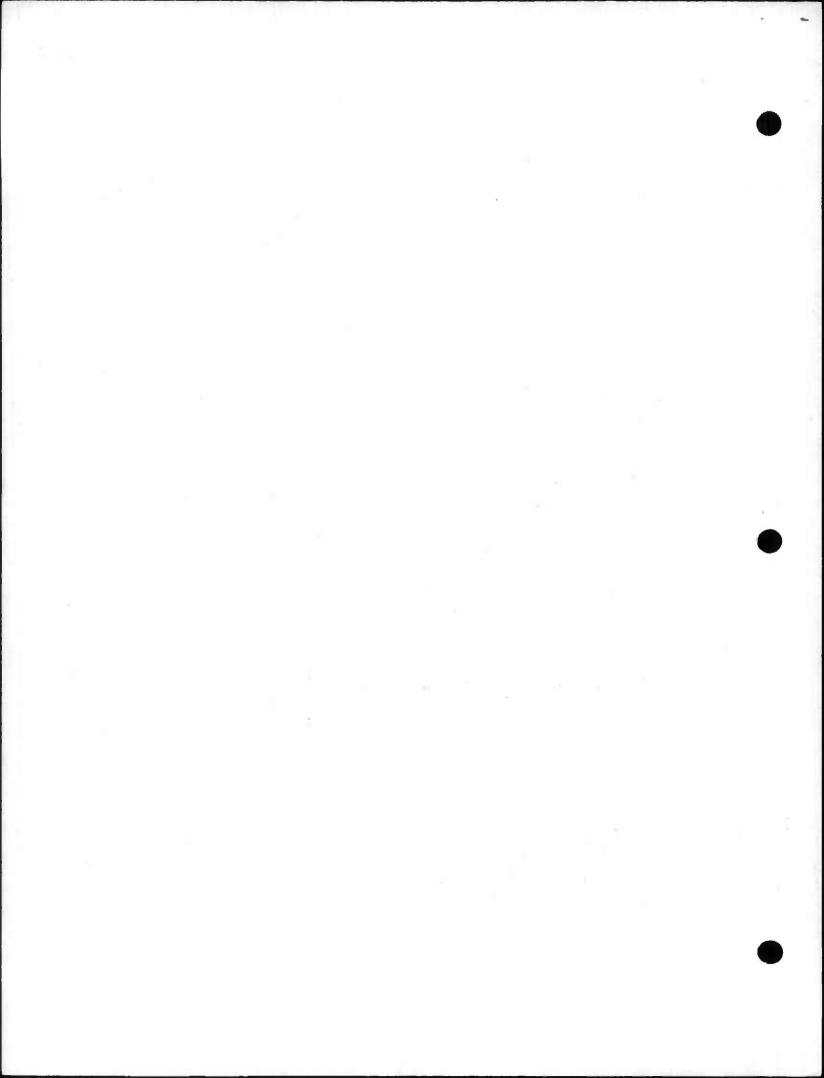
32. REGISTRAR'S SIGNATURE

Kusle

31. DATE FILED (Month, Pay, Year) 0 1994

Hoperton

Md. 21742



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | CEF | RTIFIC | CATE OF | DEATH | | REG. NO | | | |
|------------------|---|-------------------------|--------------|--|---|-------------------------|------------|--|------------------------------|--|
| - 8 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF | | | | 3. TIME OF DEATH |
| 1 | Cora Jane GLOTFEL | ГҮ | | | | Aug. | 19, | 1994 | YEAR | 5:38 P |
| | 4. SOCIAL SECURITY NUMBER S. SEX | 8. AGE (In yrs. last be | | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF (Month, I | BIRTH | | s. BIRTH Country | PLACE (State or Foreign |
| FUNERAL DIRECTOR | 220-26-9583 1 M 2 🔀 F 9e. FACILITY NAME (If not institution, give street and number) | 87 | YRS. | DAYS DAYS | HOURS MIN. | Sept. | | 1906 | | Idaho |
| | Dennett Road Manor Nursing | g Home | | | land | EATH | | | arret | |
| | 10e. STATE 10b. COUNTY | | loc, CITY, 1 | TOWN OR LOCAT | | | | | | 10d. INSIDE CITY LIMITS? |
| • | MD Garrett | | | | Accid | ent | | | | 1 YES 2 NO |
| ERAL | Rt. 1, Box 81 | | | 101 | . ZIP CODE 2 15: | 20 | | t0g. CIT | USA | /HAT COUNTRY? |
| B≺ | 11. MARITAL STATUS t Never Merried 2 Merried 3 12. WAS DECEDENT FORCES? 1 IF YES, GIVE WI | YES 2 NO | D | If yes, sp | ENDENT OF HISPAN ecify Cuben, Mexice 2 1 NO Specifi | n, Puerto Ric | | or No | 14. RACE Black Specifi | - American Indian, c, White, etc. |
| | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 18e. DECE | DENT'S US | UAL OCCUPATION |)N | 16b. K | IND OF BU | SINESS/INI | DUSTRY | |
| COMPLETED | Elementery/Secondery (0-12) College (1-4 or 5+) | life. Do | NOT use r | k done during mo etired.) sewife | st of working | | Home | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Mid | | | | |
| BE C | James Nelson Morr | is | | | Della | | ora | | andv | |
| TO B | 19e. INFORMANT'S NAME (Type/Print) | 19b. k | ALLING A | ODRESS (Street e | nd Number or Rural i | | | | - | |
| ۲ | Majorie Browning | Rt | . 3, | Box 26 | 86, Oakl | and, 1 | Maryl | and | 2155 | 50 |
| | 20e. METHOD OF DISPOSITION 1 Burlel 2 □ Cremetion 3 □ Removal from State | | | DISPOSITION (Na | | DATE | | | City or To | |
| | 4 Donetion 5 Other (Specify) | Garrett | Co. | | Gardens | | 0a | kland | l, Ma | ryland |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 2 | | Ster | wart Fundants S. Second | eral H | | land | MD | 21550 |
| | 23. PART i. Entar tha diseases or complications that | ceused the daeti | n. Do not | entar the mo | de of dying, suc | haa cerdis | c or respi | ratory er | reet. | Approximate |
| | shock, or heart fellure. List only one cause IMMEDIATE CAUSE (Final disease or condition resulting in dasth) s. Congest: | e on each line. | t fai | | | | | | | Interval Batweer Onsat and Death Chronic |
| Z | DUE TO (OR AS A CONSEQUENCE OF): Cardiomyopathy chronic | | | | | | | | | |
| ATIO | DUE TO (OR AS A CONSCOUENCE OF): the any, leading to immediate cause. Enter UNDERLYING April and Mitral Valve disease chronic | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or injury that initiated events resulting in desth) LAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | 0.000 | |
| | PART II. Other significant conditions contributing to | leath but not ras | ultina in | the undariving | cause given in | Part 1 2 | Le WAS AN | AUTOPSV | 246 | WERE AUTOPSY FINDINGS |
| EDICAL | s/p cerebrovascular accidents, s/p colon carcinoma w/o response to some serior | | | | | | | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| Σ | _evidence of recurrence | | | | | | | | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) | | | | | | | | | |
| | EXAMINER? HOSPITAL: 1 YES 2 NO 1 Inpution 2 | FR/Outpatient 3 🗆 | | THER: | | | 300 | _ | | |
| PHYSICIAN: M | 27. MANNER OF DEATH 28e. DATE OF I | NJURY 2 | Sb. TIME C | OF 28c. INJ | 5 Residence | | | NJURY OC | CURED | |
| ВУР | t Natural 5 Pending (Month, Day 2 Accident Investigation | (Year) | INJUR | M 1 WO | RK? 'ES 2 NO | | | | - | |
| | 3 Suicide 6 Could not be building, etc. (Specify) 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) | | | | | | | loute Number, | | |
| COMPLETED | 29e. CERTIFIER (Check only one) t CERTIFYING PHYSICIAN: To the best of many one) 2 MEDICAL EXAMINER: On the bests of examiners. | | | | | | | | |) end manner as stated. |
| | 29b. MONATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER 29d. DATE SIGNED | | | E SIGNED | (Month, Day, Year) | |
| TO BE | Stoke 1. Tusk. In D. | • | | | н372 | 231 | | ▶ 8 | 3/20/ | 94 |
| - | Dr. J. T. Turski, DO P.(| | | · · | ille, Man | ryland | 21. | 531 | | |
| 2 | 31. DATE FILED (Month, Day, Year) 32. REGISTRAR | 'S SIGNATURE | | | | 7 | | | | |
| \prec | AUG 2 4 1994 / 12 Au | wilen Prod | 00 | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with ours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNETAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlb-tran be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 687604

DHMH-16 Rev 1/89

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| • | - | 4 | philit. |
| s plit sort | 020 | physician | burial-transit |
| | IMORE, MARYLAND 21215-0020 | attending p | irector, page 5 should be detached for use as the burial-tra |
| | 217 | ital or | 1 for us |
| | AND | he hosp | detached |
| | ᆛ | 5 | 2 |
| | MAR | lage 6 may be retained by the hospital or attending | 5 should |
| | Æ, | nay be | page |
| | MOF | аде 6 п | director. |

BALTIA DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within yours after death. Page 6 may be retained by the hospital or | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for be filed within 72 hours after death with the State Debt, of Health and Mental Hypiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|---|--|
| ours after d | filled in by the 1 on, or removal. | e medicai ex |
| xecuted with | and completely burial, crematic | ratic event, th |
| certificate be e | iding physician Hygiene prior to | r other traum |
| that the death | hed by the atter th and Mental | any injury, o |
| he law requires | has been sign e Dept. of Hea | m 23 shows |
| PHYSICIAN: T | r this certificate | arked, or ite |
| OR ATTENDING | DUIS after death | em 28 is mi |
| TO THE HOSPITAL (| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Debt, of Health and Mental Hyglene prior to burlal, cremation, or removal. | IMPORTANT: If It |

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
|---|----------|
| CERTIFICATE OF DEATH | REG. NO. |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAND | | OF HEALTH AN | D MENTAL HYGIENE REG. NO. | | | | |
|---------------|---|---|---|--|--|-----------------|--|--|--|
| | 1. OECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF OEATH | | 3. TIME OF OEATH | | |
| | Anne I | Elizabeth | | Guy | July 23, 1 | 994 | 9:05 A M | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (In yrs. | | | RS. 7. DATE OF BIRTH | 8. BIRT | HPLACE (State or Foreign | | |
| | 215-54-7375 | 1 □ M 2 💢 F 51 | YRS. MONTHS | DAYS HOURS MI | Nov 20, 194 | 2 Count | arvland | | |
| | 9a. FACILITY NAME (If not institution, give stre | | | TOWN OR LOCATION O | | COUNTY OF | DEATH | | |
| OR | At Home, Rt. 3 Box | 267, St. John | Rd Ho | ollywood | | St. | Marv's | | |
| DIRECTOR | RESIDENCE OF DECEDENT 100, STATE 100, COUNTY | | 10c. CITY, TOWN C | OR LOCATION | | | 10d, INSIDE CITY | | |
| OIR | Maryland St. M | arv's | Holly | | | | LIMITS? | | |
| 7 | 10e. STREET AND NUMBER | ary b | 11011) | 10f. ZIP CODE | 10 | g. CITIZEN OF | WHAT COUNTRY? | | |
| FUNERAL | Rt. 3 Box 267 | | | 20635 | | U.S.A | | | |
| 5 2 | | 12. WAS DECEDENT EVER IN U.S. | | WAS DECENDENT OF HIS | SPANIC ORIGIN? (Specify Yes or N | No - 14. RAC | E — American Indian, | | |
| BY F | 1 Never Married 2 X Married 3 Wildowed 4 Divorced | FORCES? 1 YES 2 FIF YES, GIVE WAR OR DATES | | If yes, specify Cuban, Ma I ☐ YES 2 [X] NO S; | exican, Puerto Rican, etc.) | Spec | ck, White, etc. | | |
| | | | l l | - | | Whi | ite | | |
| COMPLETED | 15. DECEOENT'S EDUCA (Specify only highest grade of | completed) | DECEDENT'S USUAL OF (Give kind of work done) (Ife. Do NOT use retired.) | CCUPATION during most of working | 16b. KIND OF BUSINE | SS/INOUSTRY | | | |
| PLE | 12th Grade | College (1-4 or 5+) | Painter | | Self E | molove | d | | |
| MO | 17. FATHER'S NAME (First, Middle, Last) | | | 18 MOTHER'S | S NAME (First, Middle, Maiden Surn | | | | |
| Ö | Joseph Dav: | id Baile | ey | Mary | Theresa | | ibson | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING ADDRESS | (Street and Number or Ri | tural Route Number, City or Town, St. | rate. Zip Code) | | | |
| 5 | Thomas Wilmer Guy | | | | Lywood, Md. 20 | | | | |
| | 20a. METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Ramon | | E ANO DATE OF DISPOS | | OATE 20c. LOCATI | ON — City or T | own, State | | |
| | 4 Donation 5 Other (Specify) | | cremetory or other place) Les Memori | ial Gardens | s 7/26/94 Lec | nardto | wn, MD | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | | 22. | NAME AND ADDRESS OF | | | | | |
| | Michael | Lardin | | |), Leonardtown | | | | |
| | 23. PART Enter tha diseases, or do | implications that caused the | deeth. Do not enter | | | | Approximate | | |
| | IMMEDIATE CAUSE (Final | lst only one cause on each II | na. | 1 | | | Onset and Death | | |
| | disease or condition reaulting in death) | Corca | roma | losel | | | mo | | |
| | , | QUE TO (OR AS A CONS | SEQUENCE OF) | 111 | 1 | | 11. 3 | | |
| N | Sequantielly list conditions, | Carcin | uma | OVIM | dva | | 442 | | |
| Ā | If any, laeding to immediate cause. Enter UNDERLYING | DUE TO (OR AS A CONS | REQUENCE OF): | 1 | | | 1 | | |
| 윤 | CAUSE (Disease or Injury that Initiated events OUE TO (OR AS A CONSEQUENCE OF) | | | | | | | | |
| CERTIFICATION | resulting in death) LAST | | A. S. C. W. S. C. W. C. | | | | | | |
| 8 | DATON III. Oak as also all lands as a sile lands | | | | | | | | |
| ¥ | PART II. Other algolificant conditions | contributing to death but no | t raaulting in tha un | darlying cause giver | n in Part i. 24s. WAS AN AUT | | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | |
| MEDIC | | | | | 1 □ YES 2 🔭 | NO | OF OEATH? | | |
| Σ | DID TODA 660 HEE 64 | 01.170.101.177. 70. 641 | | 11 \ | 10. | | 1 Dyes 2 DAY | | |
| PHYSICIAN: | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 125. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check colt) (200) | | | | | | | | |
| 2 | EXAMINER? | HOSPITAL: | OTHER | 28. PLACE OF DEATH | | | ~ | | |
| HYS | 27. MANNER OF DEATH | 1 Inpetient 2 ER/Outpetient 28s. OATE OF INJURY | 3 DOA 4 Nun | sing Home 5 Resider | nce 6 Other (Specify) 26d. DESCRIBE HOW INJUS | BY OCCUPED | | | |
| | 1 Natural 5 Pending | (Month, Day, Year) | INJURY | WORK? | | 11 OCCORED | 1 | | |
| BY | 2 Accident Investigation 3 Suicida 6 Could not be | 26s. PLACE OF INJURY — At | home, term, street, fact | | 28f. LOCATION (Street and A | Yumber or Rural | Route Number, | | |
| COMPLETED | 4 Homicide determined | building, atc. (Specify) | | | City or Town, State) | | _=0.00-1 | | |
| ۳ | 29a. CERTIFIER CERTIFYING PHYSICI | IAN: To the best of my knowledge, | death occurred at the t | lme data and place and | due to the cause(s) and manner | an eleted | | | |
| 1 | OTH) 2 MEDICAL EXAMINER | On the best of ammination and/o | or/investigation, in my o | pinton, death occured at | t the time, data and place, and du | e to the cause(| a) and manner as stated. | | |
| ŏ | 296. SIGNATURE AND TITLE OF CURTIFIER | -/// | | 29c. LICENSE | | | D (Month, Day, Year) | | |
|) BE | Jan. | H bill | 75 /1 | 1 ID | 0 6419 | 77- | 25-94 | | |
| 2 | 38. NAME AND ADDRESS OF PERSON WHO | COMPLETED SADE OF DEATH (| TEM 27) (Type, Frint) | | | 10 | ~ / [| | |
| | J. Patrigk Jarbos | e, M./o./ Lec | onardtown, | Maryland | 20650 | | | | |
| | 21. DATE FILED (Month, Day, Hule) | Salia of wellow have | 1.11 | | | | | | |
| | JUL 26/1994 | galin of well or have | AGA4 | | | | | | |

in x - .

| E, MARYLAND 21215-0020 |
|------------------------|
| BALTIMOR |
| . BOX 68760, |
| P.0 |
| RECORDS, |
| OF VITAL RI |
| DIVISION |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a curs after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPAR | TMENT OF H | EALTH AND I | | E | |
|--------------------|--|---|-------------------------|---------------------------------------|------------------------------------|------------------------------|----------------|---|
| | 1, DECEDENT'S NAME (First, Middle, Last) | | CERTIF | ICATE OF | DEATH | REG. NO. | <u></u> | |
| | | | | | | 2. DATE OF DEATH DA | | 3. TIME OF DEATH |
| | | argaret 5. SEX B. AGE | Hendr | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 08 2 | | 94 12:45 A M |
| | | 1 M 2 T 5 | vee | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) | | BIRTHPLACE (State or Foreign Country) |
| | 9a. FACILITY NAME (If not institution, give stre | X_ I O | 1 113. | 01 01TV TOWN 0 | | 06/17/1 | | aryland |
| œ | | | | | OR LOCATION OF DE | ATH | 9c, COUNTY | |
| 18 | Eale Nursing F | lome, Inc. | | Lonac | oning | | Alle | gany |
| DIRECTOR | 10e, STATE 10b, COUNTY | | 10c. CIT | Y, TOWN OR LOCAT | TION | | | 10d. INSIDE CITY |
| | MD Alleg | gany | Ba | arton | | | | LIMITS? |
| FUNERAL | 10e. STREET AND NUMBER | | | 101. | . ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? |
| I E | Star Route Box | z 5 | | | 21521 | | USA | |
| 5 | | 12. WAS DECEDENT EVER II FORCES? 1 YES | N U.S. ARMED | 13. WAS DEC | ENDENT OF HISPAN | IC ORIGIN? (Specify Yes | or No- 14. | RACE — American Indian, |
| BY | 1 Never Married 2 Married 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR D | ATES | 1 Tyes, spe | ecity Cuban, Mexical 2 NO Specify | n, Puerto Rican, etc.) | | Black, White, atc. Specify: |
| | 21 | | | | | | | White |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade co | ompleted) | (Give kind of v | VOIAL OCCUPATION WORK done during mos | ON st of working | 16b. KIND OF BUS | INESS/INDUST | RY |
| 12 | Elementary/Secondary (0-12) Unicnown | College (1-4 or 5+) | Homema | | | | | |
| N N | 17. FATHER'S NAME (First, Middle, Last) | | пошеша | Ker | 40 MOTUENIO 114 | Home | | |
| - | Thomas Mowbray | | | | | ME (First, Middle, Maiden S | Sumame) | |
| H | 19a. INFORMANT'S NAME (Type/Print) | | 19b MAILING | ADDRESS (Street o | | Footen Number, City or Town | St. 17 . 0 | (.) |
| 2 | Sandra McDonough | 1 | 1 | .36 | | | | 9) |
| | 20a. METHOD OF DISPOSITION | 206 | PLACE AND DATE (| OF DISPOSITION (Na | me of | on, Md. 215 | CATION — City | or Town State |
| | 1 Donation 5 Other (Spepily) | al from State cen | netery, crematory or of | her place) Hill Cem | netery 8- | 26-9/1 Bo | rton, | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | NSEE O | 200101 | 22, NAME AN | ID ADDRESS OF FAC | CILITY | L toll, | Mu. |
| | Il well. | (//ml | | | . Funeral | | | |
| | 23. PART I. Enter the diseases, or co | mplications that caused | the death Do n | I III | Church S | t. Western | port, | Md. |
| | snock, or neert reliure. Li | at only one ceuse on e | ech lina. | or enter the mor | de or dying, sucr | i aa cardiac or respir | atory arrest, | Interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | ant | 100 < - | 0 | 1.00 | | | Onset and Death |
| | resulting in dasth) a. | DUE TO (OR AS | CONSEQUENCE OF | no Co | VA | <u></u> | | 10 min. |
| 2 | | anterine | 00.00 | Card | LOWISC | ular Dr. | SACE | 1 4000 |
| 은 | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF | 7: | -00 0000 | -0-00 | المال الماليون | o frais |
| S | CAUSE (Disease or Injury | | | | | | | |
| 뜬 | that initiated events | DUE TO (OR AS A | CONSEQUENCE OF | 7): | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | |
| | PART II. Other aignificant conditions | contributing to death b | ut not resulting I | n the underlying | cause given in i | Part I. 24s. WAS AN / | urmopey | 24b. WERE AUTOPSY FINDINGS |
| 8 | HUROSTONSIA | n - Cond | iac an | +1 | | PERFORI | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| ED | Fattle Quico d | Targerage | . AA | There | vica. | 1 D YES 2 | 9 No | OF DEATH? |
| Σ | 1 YES 2 NO | | | | | | | |
| PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) | | | | | | | |
| Sic | | HOSPITAL: | atient 3 DOA | QTHER: | | | | |
| Η | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIME | E OF 28c, INJL | URY AT | 28d. DESCRIBE HOW IN | JURY OCCURE | D |
| ВУ Р | Netural 5 Pending 2 Accident Investigation | (Month, Day, Year) | IUNI | | RK? 'ES 2 NO | -supervenes-per o | | |
| 4 1 | 3 Suicide 6 Could not be | 28a. PLACE OF INJURY | - At home, farm, a | treel, factory, office | | 28f. LOCATION (Street ar | nd Number or R | ural Route Number, |
| E | 4 Homicide detarmined | building, atc. (Spec | erry) | | | City or Town, Stafe) | | |
| | 29a. CERTIFIER 1 X CERTIFYING PHYSICA | AN: To the best of my know | edge, death occurre | d at the time, data | and place, and due t | In the cause(s) and men | nor an eleted | |
| 0 | | | | | | | | (Se(s) and manner so eteled |
| OMP | | | 1 and/or investigation | | | , provet min | | |
| COMPLETED | (Check only one) 2 MEDICAL EXAMINER: | | and/or investigation | | | DED. | *** | |
| BE | 2 MEDICAL EXAMINER: | | and/or investigation | | 29c. LICENSE NUM | BER | 29d. DATE SIG | NED (Month, Day, Year) |
| | 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE-OF CERTIFIER | On the beels of examination | | | | BER O A | 29d. DATE 9/0 | |
| BE | 2 MEDICAL EXAMINER: | On the beels of examination | ATH (ITEM 27) (Type, | | DO70 | ACONING | ▶ ⊠ ; | NED (Month, Dey, Year) 24 (9 4 |

 DIVISION OF VITAL RECORDS, P.O. BOX 68760.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1. DECEDENT'S NAME (First, Middle, Last) FLOYD | HEBB | | | | | 2. DATE OF DEATH | 19 | 94 | 3. TIME OF DEATH 4:18 p |
|---|---|--|----------------------------------|-------------------|---------------|-----------------|--|------------------------------|--|--|
| | 4. SOCIAL SECURITY NUMBER 233-34-2331 | | (In yrs. last birthday) (O) YRS. | IF UNDER | | UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) 090923 | | | IPLACE (State or Foreity) WV |
| | 9e. FACILITY NAME (If not institution, give | street and number) | | 9b. CITY, | TOWN OR L | OCATION OF E | | | NTY OF E | |
| СТОВ | SACRED HEART HO | SPITAL | | CUM | BERLA | ND, MA | RYLAND | ALI | COUNTY OF DALLEGAL CITIZEN OF V USA 14. RACE Black Special Citinoustry Dut) 2. Zip Code) 2.1502 N — City or To land, Deral 1 Cland, Triand | NY |
| 5 | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT | ~ | 40 - 00 | Y, TOWN O | | | | | | |
| DIRE | MARYLAND ALLE | | | UMBER | | | 3-1 | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 N |
| 3AL | 10e. STREET AND NUMBER | | | | 10f. ZH | CODE | | 10g. CITI | ZEN OF | WHAT COUNTRY? |
| FUNERAL | 12010 Iris Ave | | | | | 502 | | | | |
| B | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 V YE IF YES, GIVE WAR OR | S 2 NO | 11 | yes, specif | | NIC ORIGIN? (Specify en, Puerto Rican, atc.) fy: | Yee or No- | | E — American India k, White, etc. My White |
| 8 | 15. DECEDENT'S EDU (Specify only highest grad | CATION | 16a. DECEDENT'S | USUAL OC | CUPATION | unchlan | 16b. KIND OF E | SUSINESS/IND | USTRY | |
| COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | Ille. Do NOT u | nduct | | working | Railr | oad | | |
| ğ | 17. FATNER'S NAME (First, Middle, Last) | | | | 16 | . MOTNER'S N. | AME (First, Middle, Maid | en Surname) | | |
| BE | Floyd Hebb | and the state of | | | | Mamie | E. (Arme | ntrout | =) | |
| 10 8 | 19e. INFORMANT'S NAME (Type/Print) | | 19b, MAILING | ADDRESS | (Street end I | lumber or Rural | Route Number, City or 1 | fown, State, Zip | Code) | |
| - | Edith A. Hebb | | 12010 | Iris | Ave. | , Cumb | erland, M | 0. 21 | 502 | |
| | 20a. METHOD OF DISPOSITION 143 Buriel 2 Cremetion 3 Ren | noval from State | 0b. PLACE AND DATE | OF DISPOSI | TION /Name | | | | | |
| | 4 Donation 8 Other (Specify) | | unset Mer | noria. | l Par | k 8/ | 22/94 Cur | nberla | nd, | MD. |
| | 21. SIGNATURE OF FUNERAL SERVICE II | Kull | _ | 309 | -311 | Decatu | r St., Cu | Fune: mberla | and, | Home MD.2150 |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition — DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | 14 14 124 | | |
| MEDICAL | PART & Other significant condition Plantary Neuropastr | Myozard | but not requiting | cut | 196 | Tevse | PERF | AN AUTOPSY ORMED? 2 NO | 248 | WERE AUTOPSY FIN AVAILABLE PRIOR T COMPLETION DF CA OF GEATH? |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | * | | 26. PLACI | OF DEATH (C | heck only one) | | | |
| SICIAN | t YES 2 NO | HOSPITAL: | Itpatient 3 DOA | OTHER 4 Nurs | : | | 11 N | | | |
| BY PHYSICIAN: | t VES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Nome 5 Recidence 8 Other (Specify) 27. MANNER OF DEATH Natural 5 Pending Investigation 28e. OATE OF INJURY (Month, Dey, Year) 28e. TIME OF INJURY M 1 YES 2 NO 28d. DESCRIBE NOW INJURY OCCURED 1 YES 2 NO | | | | | | | | | |
| | 3 Suicide 8 Could not be 4 Nomicide determined | 28e. PLACE OF INJUI building, atc. (Se | RY At home, farm, necify) | street, facto | ry, office | LEN | 281. LOCATION (Stre City or Town, Sti | | or Rural | Route Number, |
| COMPLETE | one) | SICIAN: To the best of my kno ER: On the baels of examinat | | | | | | | | s) and manner ee st |
| TO BE COI | 296. SIGNATURE AND TITLE OF CERTIFIE | 2000 | |) | 26 | c. LICENSE NU | 135 M | 29d. DAT | E SIGNED | (Month, Day, Year) |
| | 30. NAME AND ADDRESS OF PERSON WILL Victor Mazzo 31. Date Filed (Morith, Day, Year) | occo, MD | | | Seton | Dr., | Cumberland | d, MD | 215 | 02 |
| 1 l | AUG 2 2 1994 | 32. REGISTRAN'S SIG | SNATURE !!! | | | | | | | |

| | 200 | |
|---|--|----------|
| | er this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Page the with the State Dept. of Heath and Mental Hygiene prior to burlal, cremation, or removal. | |
| e e | ansit | |
| hours after death. Page 6 may be retained by the hospital or attending physician. | rrial-tra | |
| ng ph | the bu | |
| trend | 98 | |
| al or | for us | |
| hospit | ched | |
| the ! | e deta | |
| ed by | d blue | 4 |
| retair | 5 sho | 414 |
| ay be | page | 4 4 |
| е 6 т | ector, | 1 |
| Pag. | aral di | 1 |
| death | e fune | |
| s after | by th | diam |
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| precut | and c | - Alle |
| e pe | sician vior to | A |
| tificat | g phy | Africa |
| ith cei | tendin al Hyg | - |
| he dea | Went: | The same |
| that t | h and | 1 |
| quires | Sign Healt | - |
| W rec | beer of | 3- 6 |
| G PHYSICIAN: The law requires that the death certificate be executed with | ate De | - |
| CIAN | the St | 40 |
| PHYSI | this c | 1 |
| 9 | 늘등 | 1 |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

2

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 MEGISTRAP'S SIGNATURES Julia Davidson-Rardell

Federico G. Arthes, M.D.

31. DATE FILED (MATT.) 6 1994

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATN P. Showell August 12 1994 HATTIE HENRY 1:00 A M 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 09/12/1912 & AGE (In urs lest hirthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 🗌 M 2 🖵 F 219-01-9866 81 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Worcester Berlin Nursing & Rehabilitation Center Berlin RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Worcester Maryland Berlin 1 YES 2 NO FUNERAL 10. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 10230 Georgetown Road 21811 USA 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Ri

1 YES 2 XNO Specify: 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES Specify: BY 3 Widowed 4 Divorced African American COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION 16h KIND OF BUSINESS/INDUSTRY (Give kind of work done ife. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) Private Family/Housekeeper domestic laborer 6th grade 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Daniel Showell Lizzie Purnell BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 106 Hudson Street, Berlin, Maryland 21811 Cheryl Dale 20a. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE 20s. METNOD OF DISPOSITION

XX Burlel 2 Cremetion 3 Removal from State
4 Donetion 5 Other (Specify) Evergreen Cemetery

Evergreen Cemetery 8/20 Berlin, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 1213 Jersey Road, Salisbury Jolley Memorial Chapels -Maryland 21801 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition failrace Lenel resulting in death) DUE TO JOB AS A CONSEQUENCE OF DUE TO LOR AS A CONSEQUENCE OFF: CERTIFICATION Sequentially list conditions, If any, leading to immediata cause. Enter UNDERLYING ntennos cherons CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events. reaulting in death) LAST PART ii. Other, eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL MAIL ABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 WES 2 X NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) EXAMINER? HOSPITAL OTHER:
4 Nursing Nome 5 Residence 6 Other (Specify) 1 Inpetient 2 ER/Outpetient 3 DOA 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 X Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident E DIRECTOR: After hours after death 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Nomicide 200 tem 29e. CERTIFIER

There are 1 X CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner as stated. TO THE FUNERAL OF TO THE FUNERAL DE FILED WITHIN 72 he IMPORTANT: If IN 2 __MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month. Day Year) BE 222 8-12.9 D02026

1622A Ocean Pines Berlin, MD 21811 410-641-6363

THE SHARE SHE STATE

| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | BALTIMORE, MARYLAND 21215-0020 |
|---|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 27 hours after death. Page 6 may be retained by the hospital or attendance properties. | after death, Page 6 may be retained by the hospital or attending physician |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burnarinal be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | the funeral director, page 5 should be detached for use as the burla-tran loval. |
| IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notitied at once. | cal examiner must be notitled at once. |

RICHARD 5
31. DATE FILED (Month, Dey. 16ar)
AUG 2 4 1994

32. REGISTRAR'S SIGNATURE

| , | FOR 1 - STATE REGISTRAR | STATE OF MARYLAND / | DEPARTMENT OF SERTIFICATE OF | | | E | | |
|----------------------|--|--|--|---|--|------------------|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | • | DEATH | REG. NO 2. DATE OF DEATH MONTH D. | AY YE | 3. TIME OF DEATH | |
| | | S. SEX 8. AGE (in yrs. less 1 | YRS. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. OR LOCATION OF DI | 7. DATE OF BIRTH (Month, Day, Year) | 3-7 ° | HRTHPLACE (State or Foreign ountry) est Virgini | |
| DIRECTOR | RESIDENCE OF DECEDENT | cen Hoge | 7211 | ston v | nd | HA | | |
| | Transport of the second | Hinds | 10c. CITY, TOWN OR LOCA | Clint(| on | Lan organi | 10d. INSIDE CITY LIMITS? 1 YES 2 NO OF WHAT COUNTRY? | |
| FUNERAL | 901 Dogwo | | | 3905 | | U | S.A. | |
| BY | 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 2. WAS DECEDENT EVER IN U.S. AR FORCES? 1 TYPES 2 THE IF YES, GIVE WAR OR DATES 1957 - 1963 | | pecify Cuben, Maxica S 2 NO Specify | NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.) y: | | RACE — American Indian, Black, White, etc. Specify: AUCASIAN | |
| COMPLETED | 15. DECEDENT'S EDUCAT (Specify only highest grade cor Elementary/Secondary (0-12) | mpleted) (G. College (1-4 or 5+) | CEDENT'S USUAL OCCUPAT the kind of work done during m Do NOT use retired.) | ost of working | 16b. KIND OF BU | | ar | |
| BE COM | 17. FATNER'S NAME (First, Middle, Last) Floyd Frank | 7-2- | 24444 | | ME (First, Middle, Maiden | Surname) | Morris | |
| TO E | 19a. INFORMANT'S NAME (Type/Print) Shirley Patrici | | b. MAILING ADDRESS (Street | ** | | | 0) | |
| | 20 METNOD OF DISPOSITION 1 Burlet 2 Cremetlon 3 Remova 4 Donation 5 Other (Specify) | 20b. PLACE / cemetery, cre HICK | AND DATE OF DISPOSITION (A | | 1_ /_ 1 | cation — city o | or Town, State | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | den Kurk- | T K | arretts | our neral Ho sville. M | me | | |
| | the second control of | mplications that caused the dast only one cause on the line day one cause on the line day one caused the day one caused the day of the line da | eath. Do not antar tha m | oda of dying, auc | h aa cardiac or reap | retory arrast, | Approximata Interval Batween | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | |
| ERTIF | that initiated events resulting in dasth) LAST d. | | | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY PERFORMED? PERFORMED? 1 YES 2 NO 1 YES 2 NO | | | | | | | |
| IAN: | DID TOBACCO USE CC | NTRIBUTE TO CAUS | | LACE OF DEATH (Ch | | | | |
| YSIC | 1 YES 2 NO 1 | OSPITAL: ER/Outpatient 3 | OTHER: | ne 5 Reeldence | | | | |
| ВУ РН | 27. MANNER OF DEATN 1 Natural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT | | | | D | |
| | 3 Suicide 6 Could not be 4 Homicide detarmined | 28a. PLACE OF INJURY — At he building, atc. (Specify) | ma, farm, streat, factory, offi | ce . | 28f. LOCATION (Street (City or Town, State) | and Number or Ru | ural Route Number, | |
| COMPLETED | | IN: To the best of my knowledge, de On the beste of examination and/or i | | | | | use(a) and menner es stated. | |
| TO BE C | 296. SIGNATURE AND TITLE OF CERTIFIER | bemo Hul | faminga and Co | 29c. LICENSE NUI | CHURCH | 29d. DATE SIG | NED (Month, Day, Year) | |
| | 30, NAME AND ADDRESS OF PERSON WHITE | COMPLETED CAUSE OF DEATH TITES | M 27) (Type, Print) 2013 | TRAPPE | CHURCH | RD | ~ | |

2013 TRAPPE CHURCH RD DARLINGTON, MARYLAND

21034

Eller took 6

| 7 | | |
|--------------------------------|--|--|
| BALTIMORE, MARYLAND 21215-0020 | th. Page 6 may be retained by the hospital or attending physician. | the former distriction of the state of the s |
| BALTIMORE, | ter death. Page 6 may be | the foregoing discount and |

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with completely filled in by the funeral director, page 5 should be detached for use as the burial-transit perhit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If hem 28 is marked, or liem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

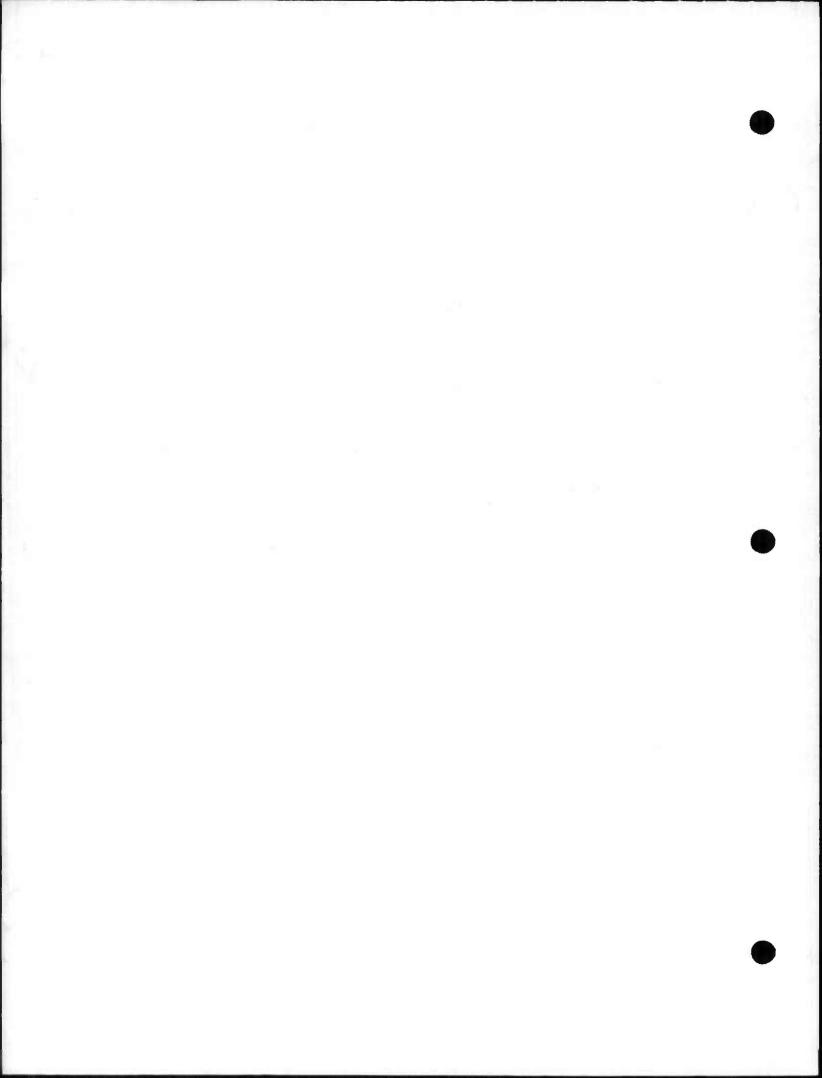
5 WP

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| 1 | 1. DECEDENT'S NAME (First, | , Middle, Last) | | | | | | | | 2. DATE OF | | | | 3. TIME OF DEATH |
|----------|---|--------------------------|---|---------------------------------|--|-------------|--------------|-------------|------------|----------------------|---------------------|------------|-----------------|--|
| | EMORY | | GEORGE | | | | Ha | RVEN | 1 JR | QUA | I MATE | 18 | 1994 | 2050 " |
| | 4. SOCIAL SECURITY NUME | ER | 5. SEX | 6. AGE (In yrs. la | st birthday) | | R 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF | HTRU | . 0 | 8. BIRTHE | PLACE (State or Foreign |
| | 215-30-432 | 9 | 1 🔀 M 2 🗌 F | 60 | YAS. | MONTHS | DAYS | HOURS | MIN. | (Month, De August | 28, 19 | 33 | Mar | yland |
| | 9e. FACILITY NAME (If not in | | | | | 9b. CIT | Y, TOWN | OR LOCATI | ON OF DE | ATH | | 9c. COU | NTY OF DE | ATN |
| DIRECTOR | PENINSULA I | | AL MEDICA | AL CENTE | ER | | SA | LISB | URY | | | W | ICOMI | CO |
| 5 | RESIDENCE OF DEC | 10b. COUNTY | , | | too CIT | V TOWAL | OR LOCA | TION | | | | | | |
| Ĭ. | Maryland | | cester | | | | an C: | | | | | | | 10d. INSIDE CITY LIMITS? |
| - 0 | 10e. STREET AND NUMBER | | cester | | | | | H. ZIP COD | - | | | 40- 017 | | 1X YES 2 NO |
| ¥ | 9911 Elm S | | | | | | " | 2 18 | | | | | ISA | HAT COUNTRY? |
| FUNERAL | 11. MARITAL STATUS | | 12. WAS DECEDEN | T EVER IN U.S. AI | RMED | 13. | WAS DE | | | HC ORIGIN? (S | nacify Vac | | | - American Indian, |
| | 1 Never Married 2 🔀 | | FORCES? 1 | YES 2 | | 1 | If yes, sp | | n, Mexica | n, Puerlo Rice | | U 140— | Black, | White, etc. |
| 'n | 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES Army | | | | | | 1016 | 2 23 110 | Specif | ,. | | | Specify Whit | |
| ED | 15. DEC (Specify only | EDENT'S EDU | CATION completed) | | ECEDENT'S Bive kind of v | | | | 200 | 16b. KIN | D OF BUS | INESS/IN | | |
| <u> </u> | Elementary/Secondary (0 | | College (1-4 or 5 a | ·} | a. Do NOT us | e retired.) | | | | | | | one i | |
| COMPLEI | 12 | | | Ra | dio d | ıspa | atche | | | | | | ean (| City, MD |
| | 17. FATHER'S NAME (First, M | 1000 | arvev | | | | | | hers na | ME (First, Midd | e, Meiden : ink) | | 11v | |
| מ | Emory Geo | U | arvey | | | | | | | | | | , | |
| 2 ∥ | Teresa Har | | | | | | | | | Route Number (| | | p Code) | |
| | 20e. METHOD OF DISPOSIT | | 4 | | AND DATE | | | | dir | DATE | , | | City or Tow | |
| | 1 Donation 5 Other | n 3 🗆 Reme | oval from State | cemetery, cri | ematory or of | ther place, |) | arrie Ur | | 8/19 | | | | |
| | 21. SIGNATURE OF TUNERA | | ENBER | - J 5al1s | bury C | | | ND ADDRE | SS OF FA | | Sal | LISDU | ıry, l | MD |
| | 1116 | 11/ | // | | | | | | | neral H | | | | |
| _ | (1) | - De | My | 1 | | | 501 | Snow | Hil | 1 Rd. | Sal | isbu | iry, l | MD 21801 |
| | 23. PART I. Enter the di shock, or hi IMMEDIATE CAUSE (Fir disease or condition resulting in death) | eart faiiUre. | e | bris | e. 2 | C | | | | | | ratory ar | rest, | Approximate interval Between Onset and Death |
| , | | _ | lt. | h . | consequence of): Humpy theut must for | | | | | | Emmitro | | | |
| HILLAHON | Sequentially list conditions if any, leading to imme- | | | | QUENCE OF | 5:7 | 7.00 | | - | | | | | - |
| 5 | cause. Enter UNDERLY! CAUSE (Disease or inju | NG | C | Mun | iose | 9 | Fun | 100 | who | Δ | | | | |
| | that initiated events resulting in death) LAS | | DUE TO | (OR AS A CONSE | OUENCE OF | F): | | 7 | | | | | | |
| F | resulting in death) LAS | | d | | | | | | | | | | | |
| | PART ii. Other significe | nt condition | s contributing to | deeth but not | regulting i | in the u | nderiyin | g ceuse | given in | Part I. 24 | . WAS AN | | 246. | WERE AUTOPSY FINDINGS |
| DICAL | | | | | | | | | | | PERFOR | MED? | - 1 | AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| 3 | | | | | | | | | | _ '' | J 163 2 | Tho | | OF DEATH? |
| | | | | | | - | | | | _ | | | | |
| TOICIAN: | 25. WAS CASE REFERRED TO | O MEDICAL | | | | | 26. P | LACE OF D | EATN (Ch | eck only one) | | | | |
| 6 | 1 YES 2 NO | | 28. PLACE OF DEATN (Check only one) HDSPITAL: 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | | | |
| | 27. MANNER OF DEATN | | 28e. DATE OF (Month, D | | 26b. TIM | | 28c. IN. | JURY AT | | 28d. DESCRI | | JURY OC | CURED | |
| | | Pending Investigation | (11107111, 12 | ay, roury | | М | _ | YES 2 |] NO | | | | | |
| 2 | 3 Sulcide 6 | Could not be | 26e. PLACE O building, | F INJURY — At he atc. (Specify) | ome, ferm, s | street, fec | ctory, offic | ce | | 281. LOCATIO | N (Street a. | nd Numbe | r or Rural Ro | oute Number, |
| - 11 | 4 Nomicide | determined | | | | | | | | | ,, | | | |
| | 29e. CERTIFIER (Check only | IFYING PHYSI | CIAN: To the best of | my knowledge, d | eath occurre | d at the | time, date | end place | , end due | to the cause(e |) and man | ner ee ats | ted. | |
| 5 | one) 2 MEDI | ICAL EXAMINE | R: On the basie of e | xemination end/or | Investigatio | n, in my | opinion, | death occur | red at the | time, date end | place, end | d due to t | he cause(s) | and manner ee stated. |
| | 296. SIGNATURE AD MILE | OF CERTIFIER | | | | | | 29c, LICI | ENSE NUI | MBER | | 29d. DAT | E SIGNED | (Month, Day, Year) |
| | 1 | rom | 20 | | | | | 0 | 20 | 507 | | • | 8/19 | 194 |
| | 30. NAME AND ADDRESS OF | PERSON WH | O COMPLETED CAUS | SE OF DEATH (ITE | M 27) (Type, | Print) | | | | 01 | | | - | |
| | Joseph | n. (| JRM SSE | 10 | 45 | E. | CA | RRO | u | 74 | 574 | 45 | BUR | WW W |
| | AUG 2 | 3 1994 | 32. TEGISTRA | audion-Ro | rdall | | | | | | | | | / |

DHMH-18 Rev 1/89

| | 1 - STATE REGISTRAR | STATE OF MARY | | | F HEALTH AND OF DEATH | | HYGIENE REG. NO. | | |
|-------------------------------------|--|--|--|--|--|--|---|----------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last, |) | 02.111 | II TOATE | JI DEAIII | 2. DATE OF | OEATH | - 67 | 3. TIME OF DEATH |
| | PHILIP | THOMAS | HERB | | | August | 18. 1994 | YEAR | 6:00 a M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 8. AC | GE (In yrs. last birthd | | | 7. DATE OF | BIRTH | 8. BIRT | HPLACE (State or Foreign |
| | 199-20-8310 | 1 🔀 M 2 🗌 F | 65 YR | S. MONTHS D | AYS HOURS MIN. | December | er 2, 1928 | Peni | nsylvania |
| | 9e. FACILITY NAME (If not institution, give | street and number) | | 9b. CITY, TO | WN OR LOCATION OF D | | | OUNTY OF I | |
| OH | 1603 S. Divisio | n St. | | Sa | lisbury | | | Wicon | mico |
| ויי | RESIDENCE OF DECEDENT 10a, STATE 10b, COUN | | 100 | CITY, TOWN OR I | OCATION | | | | 10d. INSIDE CITY |
| DIRECTOR | | .comico | 100. | Salisb | | | | | LIMITS? |
| | 100. STREET AND NUMBER | Comico | | Jaiisb | 101. ZIP CODE | | 100.0 | CITIZEN OF | 1 YES 2 X NO |
| RA | 1603 S. Divisio | n St | | | 21801 | | log. | USA | mai countri |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVE | R IN U.S. ARMED | 13, WA | DECENDENT OF HISPA | NIC ORIGIN? (S | Specify Yes or No- | | E — American Indien. |
| E | 1 Never Married 2 Married | s, specify Cuban, Mexico YES 2 X NO Specific | en, Puerto Rica | | Spec | ck, White, atc. | | | |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE WAR OF | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | ite |
| COMPLETED | 15. OECEDENT'S ED (Specify only highest grad | PATION ng most of working | 16b. Kill | INDUSTRY | | | | | |
| 4 | Elementary/Secondary (0-12) | College (1-4 or 5+) | | OT use retired.) | | | | | |
| Σ | 12 | | Flight | Service s | | | A.A. | | |
| | 17. FATHER'S NAME (First, Middle, Last) | .) | | | | | lle, Maiden Surmam | _ | |
| H | Paul (ur | nk) Her | | | Ruth | | ille | Irv | 'in |
| 2 | 19e. INFORMANT'S NAME (Type/Print) | | | | treet and Number or Rural | | | | 901 |
| | Norma J. Herb | | | | vision St. | | | | |
| | 1 Buriel 2 X Cremation 3 Res | movel from State | 20b. PLACE AND DA cemetery, crematory | or other plece) | | 8/20 | 20c. LOCATION | | |
| | 21. SIGNATURE OF PUNERAL SERVICE L | | Salisbur | | LOTY ME AND ADDRESS OF FA | | Salis | bury, | MD |
| | ·ALm A | 00 | | Нс | 11oway Fun | neral H | | | |
| _ | HAS11. HO | Chury | | | I Snow Hil | | | | MD 21801 |
| | 23. PART I. Enter the diseases, or ahock, or heert failure | complications that cau b. Liet only one couse or | sed the death. I n eech lina. | Do not enter the | mode of dying, suc | ch as cardiac | or respiratory | arrest, | Approximate interval Between |
| | ahock, or heert failure. Liet only on ceuse on eech lina. IMMEDIATE CAUSE (Final | | | | | | | | |
| - 1 | disease or condition resulting in death) a. METASTATIC LUNG CANCER | | | | | | | | 2 MONTH |
| - 1 | resenting in ecentry | | | | | | | | , |
| | Toolong III doubly | | AS A CONSEQUENC | E OF): | | | | | i |
| NO | Sequentially liet conditions, | DUE TO (OR A | | | | | | | |
| ALION | | DUE TO (OR A | AS A CONSEQUENC | | | | | | |
| FICATION | Sequentially liet conditione, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | DUE TO (OR A | | CE OF): | | | | 7.7.1 | , |
| HILICALION | Sequentially list conditions, if eny, laading to immediata cause. Enter UNDERLYING | DUE TO (OR A | AS A CONSEQUENC | CE OF): | | | | | |
| CEMILLICATION | Sequentially liet conditione, if eny, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR A DUE TO (OR A C. DUE TO (OR A | AS A CONSEQUENC | E OF): | | | | | |
| 1 | Sequentially liet conditione, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR A c. DUE TO (OR A d | AS A CONSEQUENC | E OF): | rlying cause given in | | a. WAS AN AUTOP PERFORMED? | | b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO |
| 1 | Sequentially liet conditione, if eny, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR A DUE TO (OR A C. DUE TO (OR A | AS A CONSEQUENC | E OF): | rlying cause given in | | | | |
| MEDICAL | Sequentially liet conditione, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reauting in death) LAST PART II. Other significant conditions of the company of the c | DUE TO (OR A DUE TO (OR A C. DUE TO (OR A d. Ons contributing to deet | AS A CONSEQUENC | E OF): | | | PERFORMED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDICAL | Sequentially liet conditione, if eny, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition COPD DID TOBACCO USE | DUE TO (OR A DUE TO (OR A C. DUE TO (OR A d. Ons contributing to deet | AS A CONSEQUENC | E OF): ing in the unde | YES N | 0 🗆 | PERFORMED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | Sequentially liet conditione, if eny, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition COPD DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | DUE TO (OR A DUE TO (OR A DUE TO (OR A DUE TO (OR A DUE TO (OR A DUE TO (OR A DUE TO (OR A DUE TO (OR A DUE TO (OR A DUE TO (OR A | AS A CONSEQUENCE AS A CONSEQUENCE The but not resulting | OF DEATH | YES No | O D | PERFORMED? YES 2 NO | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | Sequentially liet conditione, if eny, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant condition PACOMO DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 RYES 2 \(\) NO | DUE TO (OR A DUE TO (OR A C. DUE TO (OR A DUE TO (OR A DUE TO (OR A DUE TO (OR A DUE TO (OR A DUE TO (OR A DUE TO (OR A DUE TO (OR A | AS A CONSEQUENCE AS A CONSEQUENCE The but not results O CAUSE Dutpetlent 3 DO | OF DEATH | YES No | neck only one) | PERFORMED? YES 2 NO | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: MEDICAL | Sequentially liet conditione, if eny, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition PACONO OPD DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 RYES 2 NO 27. MANNER OF DEATH Mistural 5 Pending | DUE TO (OR A b. DUE TO (OR A c. DUE TO (OR A d. DUE TO | O CAUSE Dutpetlent 3 DORY 28b. | OF DEATH | 1 YES No. 28. PLACE OF DEATH (C/I Home 5 Residence INJURY AT WORK? | neck only one) | PERFORMED? YES 2 NO | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| BY PHYSICIAN: MEDICAL CERTIFICATION | Sequentially liet conditione, if eny, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition PACOMO COPD DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 RYES 2 NO 27. MANNER OF DEATH Solution Significant conditions of the conditions o | DUE TO (OR A b. DUE TO (OR A c. DUE TO (OR A d. DUE TO | AS A CONSEQUENCE AS A CONSEQU | OF DEATH | PLACE OF DEATH (C) Home S Residence C. INJURY AT WORK? YES 2 NO | heck only one) 6 Other (S) 26d. DE\$CRI | PERFORMED? YES 2 NO | OCCURED | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| BY PHYSICIAN: MEDICAL | Sequentially liet conditione, if eny, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition PACOMO COPD DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 RYES 2 NO 27. MANNER OF DEATH Manual 5 Pending | DUE TO (OR A b. DUE TO (OR A c. DUE TO (OR A d. DUE TO | AS A CONSEQUENCE AS A CONSEQUENCE The but not recultive to the but no | OF DEATH | PLACE OF DEATH (C) Home S Residence c. INJURY AT WORK? YES 2 NO | heck only one) 6 Other (S) 26d. DESCRI | PERFORMED? YES 2 NO | OCCURED | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| BY PHYSICIAN: MEDICAL | Sequentially liet conditione, if eny, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition PACOMO. COPD DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 PYES 2 NO 27. MANNER OF DEATH Substrail 5 Pending investigation 2 Accident 3 Suicide 6 Could not be distermined | DUE TO (OR A b. DUE TO (OR A c. DUE TO (OR A d. DUE TO | AS A CONSEQUENCE AS A CONSEQUENCE The but not recultive CO CAUSE Dutpetient 3 DO RY ary 28b. URY — At home, fair | OF DEATH OF DEATH OTHER: DA 4 Nursing TIME OF INJURY M | YES No. 28. PLACE OF DEATH (CI Home 5 Residence C. INJURY AT WORK? YES 2 NO office | heck only one) 6 Other (S) 26d. DESCRI 281. LOCATE City or X | PERFORMED? YES 2 NO Decity) Decity) Decity in Jury ON (Street and Num own, State) | OCCURED | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| BY PHYSICIAN: MEDICAL | Sequentially liet conditione, if eny, laading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition PACOMO. COPD DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 PYES 2 NO 27. MANNER OF DEATH Mustural 5 Pending Investigation 2 Accident 6 Could not be distermined 29a. CERTIFIER (Check only) | DUE TO (OR A b. DUE TO (OR A c. DUE TO (OR A d. DUE TO | O CAUSE Dutpetient 3 DO RY 28b. URY — At home, fair nowledge, death occurrence. | OF DEATH OF DEATH OF DEATH OF A 4 Nursing TIME OF INJURY M rm, streat, fectory | A YES No. 28. PLACE OF DEATH (C/L) Home 5 Residence C. INJURY AT WORK? YES 2 NO office | o ther (S) 6 Other (S) 26d. DESCRI 26f. LOCATH City or X | PERFORMED? YES 2 NO Decity) Decity) DN (Street and Num own, State) | OCCURED | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL | Sequentially liet conditione, if eny, laading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reauting in death) LAST PART II. Other aignificant condition PACOAO COPD DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 PYES 2 NO 27. MANNER OF DEATH Substural 5 Pending Investigation 1 Suicide 6 Could not be distermined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN | DUE TO (OR A b. DUE TO (OR A c. DUE TO (OR A d. DIE TO | O CAUSE Dutpetient 3 DO RY 28b. URY — At home, fair nowledge, death occurrence. | OF DEATH OF DEATH OF DEATH OF A 4 Nursing TIME OF INJURY M rm, streat, fectory | A YES No. 28. PLACE OF DEATH (C/L) Home 5 Residence C. INJURY AT WORK? YES 2 NO office | o ther (S) 6 Other (S) 26d. DESCRI 26f. LOCATH City or X | PERFORMED? YES 2 NO Decity) BE HOW INJURY ON (Street and Num own, State) a) end manner as d place, and dua 8 | OCCURED there or Rural stated. | ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, (s) and manner as stated. |
| COMPLETED BY PHYSICIAN: MEDICAL | Sequentially liet conditione, if eny, laading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition PACOMO. COPD DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 PYES 2 NO 27. MANNER OF DEATH Mustural 5 Pending Investigation 2 Accident 6 Could not be distermined 29a. CERTIFIER (Check only) | DUE TO (OR A b. DUE TO (OR A c. DUE TO (OR A d. DIE TO | O CAUSE Dutpetient 3 DO RY 28b. URY — At home, fair nowledge, death occurrence. | OF DEATH OF DEATH OF DEATH OF A 4 Nursing TIME OF INJURY M rm, streat, fectory | A YES No. 28. PLACE OF DEATH (C/L) Home 5 Residence INJURY AT WORK? YES 2 NO. office data and place, and duction, death occured at the | o Other (S) 26d. DESCRI 26f. LOCATIC City or X e to the cause(| PERFORMED? YES 2 NO Decity) BE HOW INJURY ON (Street and Num own, State) a) end manner as d place, and dua 8 | OCCURED there or Rural stated. | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially liet conditione, if eny, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant condition PACOMO COPD DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 PYES 2 NO 27. MANNER OF DEATH Netural 5 Pending Investigation 3 Suicide 6 Could not be distermined 29a. CETIFIER (Chack only one) 2 MEDICAL EXAMINERS 29b. SIGNATURE 10 TITLE OF CETIFIER 29b. SIGNATURE 10 TITLE OF CETIFIER | DUE TO (OR A b. DUE TO (OR A c. DUE TO (OR A d. DUE TO | AS A CONSEQUENCE AS A C | OF DEATH OF DEATH OF DEATH OF A 4 Nursing TIME OF INJURY M rm, atreat, fectory | PLACE OF DEATH (CA | o Other (S) 26d. DESCRI 26f. LOCATIC City or X e to the cause(| PERFORMED? YES 2 NO Decity) BE HOW INJURY ON (Street and Num own, State) a) end manner as d place, and dua 8 | OCCURED there or Rural stated. | ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, (s) and manner as stated. |
| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially liet conditione, if eny, laading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition PACOMO. COPD DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 PYES 2 NO 27. MANNER OF DEATH Medical Suicide 6 Could not be distermined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE NO TITLE OF CERTIFIES 30. NAME AND ADDRESS OF PERSONA | DUE TO (OR A DUE TO (OR A C. DUE TO (OR A | AS A CONSEQUENCE AS A CONSEQUENCE AS A CONSEQUENCE AS A CONSEQUENCE AS A CONSEQUENCE Dutpetion 3 DO RY 28b. Dutpetion 3 DO RY 28b. DURY — At home, fair Specify) rowledge, death occurrence stion and/or investig | OF DEATH OF DEATH OF DEATH OTHER: DA 4 Nursing TIME OF INJURY M rm, streat, fectory curred at the time getion, in my opin | A YES No. 28. PLACE OF DEATH (C/C) Home 5 Residence C. INJURY AT WORK? YES 2 NO office data and place, and due lon, death occured at the | beck only one) 6 Other (S) 26d. DESCRI 28f. LOCATIC City or R e to the cause(i) time, data and | PERFORMED? YES 2 NO Decity) BE HOW INJURY ON (Street and Num own, State) a) end manner as d place, and dua 8 | OCCURED there or Rural stated. | ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, (s) and manner as stated. |
| PHYSICIAN: MEDICAL | Sequentially liet conditione, if eny, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition PACOMO. COPD DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 PYES 2 NO 27. MANNER OF DEATH Suitural 5 Pending Investigation 3 Suicide 6 Could not be distermined 29a. CETTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE TO TITLE OF CETTIFIER (Check only one) 1 MEDICAL EXAMINERS 30. NAME AND ADDRESS OF PERSONAR | DUE TO (OR A DU | AS A CONSEQUENCE AS A CONSEQU | OF DEATH OF DEATH OF DEATH OF A 4 Nursing TIME OF INJURY M orm, atreat, fectory curred at the time getion, in my opin | A YES No. 28. PLACE OF DEATH (C/C) Home 5 Residence C. INJURY AT WORK? YES 2 NO office data and place, and due lon, death occured at the | beck only one) 6 Other (S) 26d. DESCRI 28f. LOCATIC City or R e to the cause(i) time, data and | PERFORMED? YES 2 NO Decity) BE HOW INJURY ON (Street and Num own, State) a) end manner as d place, and dua 8 | OCCURED there or Rural stated. | ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, (s) and manner as stated. |
| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially liet conditione, if eny, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition PACOMO. COPD DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 PYES 2 NO 27. MANNER OF DEATH Suitural 5 Pending Investigation 3 Suicide 6 Could not be distermined 29a. CETTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE TO TITLE OF CETTIFIER (Check only one) 1 MEDICAL EXAMINERS 30. NAME AND ADDRESS OF PERSONAR | DUE TO (OR A DUE TO (OR A C. DUE TO (OR A | AS A CONSEQUENCE AS A CONSEQU | OF DEATH OF DEATH OF DEATH OF A 4 Nursing TIME OF INJURY M orm, atreat, fectory curred at the time getion, in my opin | A YES No. 28. PLACE OF DEATH (C/L) Home 5 Residence INJURY AT WORK? YES 2 NO. office data and place, and duction, death occured at the | beck only one) 6 Other (S) 26d. DESCRI 28f. LOCATIC City or R e to the cause(i) time, data and | PERFORMED? YES 2 NO Decity) Decity) DN (Street and Nun DN (Street and Nun a) end manner as d place, and dua 8 | OCCURED there or Rural stated. | ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, (s) and manner as stated. |



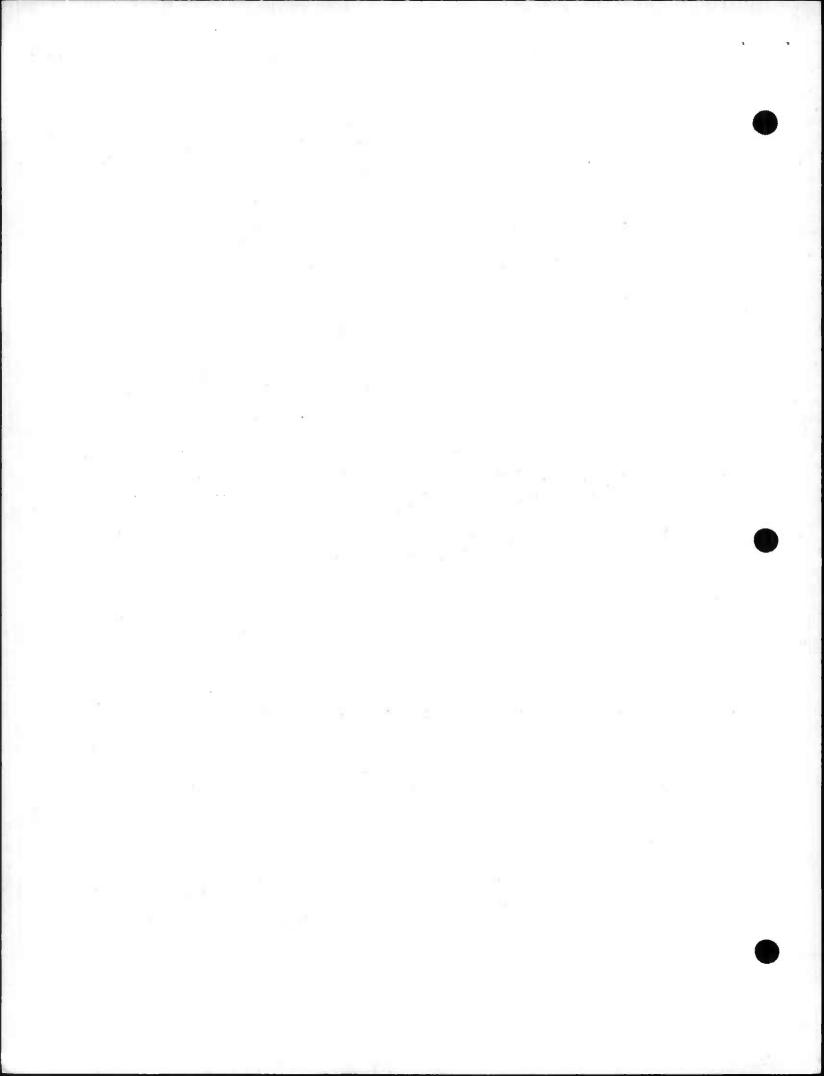
TO BE COMPLETED BY FUNERAL DIRECTOR

| 1 - STATE REGISTRAR | | STATE OF I | MARYLAND / | | | | EALTH A DEATH | | | | E | | | |
|--|-------------------------|------------------------|----------------------------------|--------------|---------------|------------------|--|---------|-------------------------|-------------------------------|------------|---------------------------------------|--|----------|
| 1. DECEDENT'S NAME (First | , Middle, Lest) | | | | IOAIL | <u> </u> | DLAIT | _ | 2. DATE OF | REG. NO. | _ | | 3. TIME OF DEAT | н |
| JOSEPH | | ALEXANI |)ER | | нт | GGS | | | JUL | V 26 | , 199 | YEAR | 6.00P | |
| 4. SOCIAL SECURITY NUMBER | ER | 5. SEX | 6. AGE (In yrs. le: | t birthday) | IF UNDER 1 | | IF UNDER 24 | HRS | 7. DATE OF | | , 1,) | | PLACE (State or Fo | |
| 217-19-811 | 1 | 1 ☑ M 2 ☐ F | 13 | YRS. | MONTHS | DAYS | | MIN. | (Month, L AUGUST | Day, Year) | 280 | Country |) | |
| 9a. FACILITY NAME (If not in | | treet and number) | 15 | | 9b. CITY | TOWN O | R LOCATION | | | 13, 13 | 9c. COUN | | INGTON, | р.с. |
| CLEMEN | TS MD | RT.24 | 12 | | | | ENTS | | | | | | ARYS | |
| RESIDENCE OF DEC | EDENT | | | | | | | | | | | | | |
| MARYLAND | 106. COUNTY | MARY¹S | | | Y, TOWN OF | | ON | | | | | | 10d. INSIDE CITY | |
| 10e. STREET AND NUMBER | 31. | MAKI 5 | | A | VENUE | _ | 717.0005 | | | | | | 1 YES 2 | NO |
| 23217 COLT | ONS PO | INT ROAD | | | | | 20609 | | | | | | STATES | |
| 11. MARITAL STATUS 1 X Never Married 2 3 Wildowed 4 Divo | | | T EVER IN U.S. AF YES 2 X | | 11 | yes, spe | ENDENT OF P city Cuban, 1 2 📉 NO | Maxica | n, Puerto Ric | | or No— | 14. RACE Black, Specifi WH] | | in, |
| | EDENT'S EDUC | | 16a. DE | CEDENT'S | USUAL OC | CUPATIO | N of working | | 16b, K | IND OF BUS | INESS/IND | JSTRY | | |
| Elementary/Secondary (0 | | College (1-4 or 5 | liho | . Do NOT us | retired.) | anny mos | a or working | | | | | | | |
| 8 | | | | STUD | ENT | | | | | | | | | |
| 17. FATHER'S NAME (First, M WILLIAM JE | | TCCS SR | | | | | | | ME (First, Mid RIE D | | Sumame) | | | |
| 19a, INFORMANT'S NAME (| | 1005, 51 | | - MAH ING | ADDRESS | (Character 1) | | | | | 0 | | | |
| INA MARIE | ,, | | | | | | nd Number or S POTI | | | | | , | LAND 206 | 00 |
| 20e. METHOD OF DISPOSIT 1 | n 3 ☐ Rame | oval from State | 20b. PLACE cemetery, cre | AND DATE O | OF DISPOSIT | TION (Nat | ne of | | DATE | 20c. LOC | CATION — C | ity or Tov | rn, State | |
| 4 Donation 5 Other | | GISEE.4 | TRINI | TY M | | | GARDE | | | | DORF, | MAI | RYLAND | |
| MICHAE | 10 | LANKENSH | IP | | | | PADDRESS FIELD ROX 27 | | | | JN M | ARVI. | AND 206 | 50 |
| IMMEDIATE CAUSE (Fir disease or condition resulting in desth) Sequentially list condit if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or injuthat initiated events resulting in death) LAS | Iona, diete NG ry | c | (OR AS A CONSE | OUENCE OF | | | | | | | | | Interval Bo | |
| PART II. Other eignifice | nt condition | e contributing to | death but not i | resulting l | In the unc | ierlying | ceuee give | en in I | | PERFORI | MED? | | WERE AUTOPSY FI AVAILABLE PRIOR COMPLETION OF C OF DEATH? | ro |
| | | | | | | | | | _ | ~ | | | 1 YES 2 1 | 10 |
| DID TOBACC | | CONTRIBUT | E TO CAU | SE OF | DEAT | H Y | ES 🗌 | NO | | | | | / ~ | - 1 |
| 25. WAS CASE REFERRED TO EXAMINER? | O MEDICAL | HOSPITAL: | | T | OTHER | | ACE OF DEAT | TH (Che | ck only one) | | | | | |
| X1X1 YES 2 NO | | 1 Inpatient 2 | | | 4 🗆 Nursi | ng Home | 5 🗆 Raald | lenca | 6-L-Other (S | | | STR | EET | |
| 27. MANNER OF DEATH 1 Ngtural 5 | Pending 1 | 28a. DATE OF | lay, Year) | | URY | 28c. INJL WOI | RK7 | | DO W | NIBE HOW IN | . / 0. | URED | FIXE | |
| 2 Accident | Investigation | 7- P | 6. ay | 1 | SO M | 1 🗌 Y | | 10 | -06 | ECT | - 0 | uis | DON | |
| | Could not be datarmined | building, | F INJURY A1 ho etc. (Specify) | me, farm, 1 | street, lacto | ry, office | | | 28f. LOCATI | ON (Street au Town, State) | nd Number | or Rural Ro | oute Number, | |
| 29a. CERTIFIER | | | | TE | SF | 1 | | | KM- | 24-2 | - CK | my | 45, N | 111 |
| (Check only | | CIAN: To the beat of a | | | | | | | | | | | and menner as st | ated. |
| 29b. SIGNATURE AND TITLE | OF CERTIFIER | | | | | | 29c. LICENS | SE NUM | BER | T | 29d. DATE | SIGNED | (Month, Day, Year) | |
| (0) | 7 | M | | | | | 0. | С. | M.E | | | ULY | | 94 |
| 30. NAME AND ADDRESS OF | PERSON WH | O COMPLETED CAU | SE OF DEATH (ITE | M 27) (Type, | Print) | _ | 0 | | | | | ~ | ,, | |
| M | M (M | DN 1 | 1 Penn | _St1 | reet | , В | altin | nor | e, M | arvl | and | 212 | 01 | |
| 31. DATE FILED (Month, Day, | Year) | 32. REGISTRA | R'S SIGNATURE | | | | | | | | | | - | |
| 111 2 | 1994 | Jalia d'a | wilson Ran | tally | | | | | | | | | | |
| 002 | - | 0 | | | 11 | | | | | | | | DHMH-16 | Rev 1/80 |

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and long refer death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



| | 1 - STATE REGISTRAR | STATE OF N | / MARYLAND / Ce | | | | EALTH DE AT | | MENTA | REG. NO. | E | | |
|--------------------|--|--|------------------------------------|-------------|--------------|--------------|-------------------------------|-----------------|--------------------------|------------------------------------|---------------|--------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) Susie | Marie | | Hill | | | | | 2. DATE MONTH AUGU | of DEATH | 1994 | YEAR | 3. TIME OF DEATH 12:30 A M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. las | birthday) | IF UNDER | R 1 YEAR | IF UNDER | 24 HRS. MIN. | 7. DATE | OF BIRTH | 1912 | Count | HPLACE (State or Foreign ry) |
| | 215-24-6014 9e. FACILITY NAME (If not institution, give s | | 80 | 1110. | 9b. CITY | r, TOWN C | R LOCATIO | ON OF DE | AUG ATH | . 2/19 | 94 9c. COU | | ryland DEATH |
| DIRECTOR | At Home, Bushwood | City Roa | ad | | Bus | shwo | od | | | | St. | Maı | ry's |
| SEC. | 10a. STATE 10b. COUNT | Υ | | 10c. CIT | Y, TOWN | OR LOCAT | ION | - | | | | | 10d. INSIDE CITY |
| | Maryland St | . Mary's | | | Bus | hwoo | đ | | | | | | LIMITS? 1 TYES 2 NO |
| FUNERAL | 10e. STREET AND NUMBER | | | | | 101 | ZIP CODE | | | | 10g. CITI | ZEN OF | WHAT COUNTRY? |
| NEI | Bushwood City Ro | 12. WAS DECEDEN | T EVER IN I. C. AR | MED | - 10 | | 206 | | | | | U.S | |
| ВҰ | 1 Never Married 2 Married 3 Wildowed 4 Divorced | FORCES? 1 | YES 2 N | IO | | If yes, spe | endent of city Cubar 2 XNO | n, Maxica | n, Puerto F | i? (Specify Yea Rican, etc.) | or No— | 14. RACI Blac Spec | E American Indian, k, White, etc. #y: Black |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | (Gi | CEDENT'S | work done | during mo. | N st of workin | a | 16b. | KIND OF BUS | SINESS/IND | USTRY | |
| | Elementary/Secondary (0-12) | College (1-4 or 5 | iife. | Do NOT u | sa retired.) | 17.5 | | • | | _ | - | _ | |
| OMF | 7th Grade 17. FATHER'S NAME (First, Middle, Last) | | Bu | s Dr | iver | | 10 MOTH | IED'S NA | _ | Board Middle, Malden | | duca | tion |
| | | Dyson | | | | | | san | ME (FRSI, A | Anna | | book | land |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) | | 190 | . MAILING | ADDRES | S (Street a | nd Number | or Rural F | Route Numb | ber, City or Town | n, State, Zip | Code) | |
| - | Delores Magnani | | - | P.O. | Box | 81, | Grea | at M | ills | , Mary | land | 206 | 34 |
| | 20a. METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | oval from State | cametery, cre | matory or o | ther place) | | | | DATI | | CATION — | • | |
| - 1 | 21. BIQHAYURE OF FUNERAL SERVICE LIC | SHREE / | Sacre | d_He | art 83. | Ceme | PARPRES | 8/6 \$ 95.EN | /199. | 4 L Bu | shwo | DG. | Maryland e, P.A. |
| | Michael | Laro | liner | | P | .0. 1 | 30x 2 | 270, | Leor | nardto | wn, M | lary. | land 20650 |
| | 23. PART Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. A | (OR AS A CONSEC | Ro | ne | 1 | For a | | | diac or respi | relory arr | est, | Approximate interval Between Onset and Daath |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c | (OR AS A CONSEC | DUENCE O | F): | | | | | | | | |
| PHYSICIAN: MEDICAL | | inors | ٥١ | li | A | | | iven in | Part I. | 24a. WAS AN PERFOR 1 - YES 2 | MED? | 246 | MERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 |
| AN | DID TOBACCO USE C | ONTRIBUTE | TO CAUS | E OF | DEAT | | ACE OF DI | NO | X. | in) | | | |
| SIC | EXAMINER? | HOSPITAL: | ER/Outpatient 3 | □ DOA | OTHE! | R: | 5 A Ra | - | | | | | |
| 품 | 27. MANNER OF DEATH | 28a. DATE OF (Month, D | INJURY | 28b. TIM | | 28c. INJ | JRY AT | | | CRIBE HOW II | NJURY OCC | URED | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | | | | М | 1 🗆 1 | ORK? | | | | | | |
| | 3 Suicida 8 Could not be 4 Homicide detarmined | 28a. PLACE O building, | F INJURY — At ho etc. (Specify) | ma, farm, | etraal, fac | tory, office | | | | ATION (Street a or Town, State) | and Number | or Rural i | Route Number, |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICONE) 2 MEDICAL EXAMINE | CIAN: To the best of R: On the basis of a | | | | | | | | | | | a) and manner as stated. |
| BEC | 296. SIGNATURE AND TITLE OF CENTIFIE | 1 | | | | | 29c, LICE | NSE NUN | IBER | | 29d. DATE | E SIGNED | (Month, Day, Year) |
| B P | 1 | 1/ | | | | | D | 19 | 91 | 2 | D 8 | 7/2 | 194 |
| - | / / | .D. CAUS | | | | n, M | aryla | and | 206 | 50 | | 17 | |
| | 31. DATE SCED (Month, Day, Year) AUG 03 19 | 32 REGISTRA | R'S SIGNATURE | ardall | | | | | | | | | |

DHMH-18 Rev 1/89



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | BALTIMORE, MARYLAND 21215-0020 |
|---|--|
| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Jours after death. Page 6 may be retained by the hospital or attending physician. | ours after death. Page 6 may be retained by the hospital or attending physician, |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | d in by the funeral director, page 5 should be detached for use as the burial-transi or removal. |
| IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | medical examiner must be notified at once. |

PHYSICIAN: MEDICAL CERTIFICATION

BY

COMPLETED

BE

2

27. MANNER OF DEATH

8 Could not be determined

2 Accident

3 Suicide

4 Nomicide

| | | | | | | | | | | | 74 | 707 | . 1 0 |
|--------|--|--|-------------------------------|------------------------------|-----------------|-----------------------|--------------------|---------------------------|---|--------------|----------------|---------------------------|---------------------------------|
| | 1 - FOR STATE REGISTRAR | STATE OF N | | / DEPAR | | | | | MENTAL HYGIEN | _ | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF DEATH | LV. | YEAR 3 | TIME OF D | EATH |
| ğ | Margaret | Hele | ene | | Hoda | 25 | | | August 3. | 199 | | 10- | 00 1 |
| - 8 | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. le | | IF UNDER | | IF UNDER | 24 HRS. | 7 DATE OF BIRTH | | 8. BIRTNPL | ACE (State o | |
| | 578-34-3126 | 1 🗌 M 2 🔀 F | 94 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, Day, Year) Nov. 7 | 1899 | Mary Mary | land | |
| -1 | 9a. FACILITY NAME (If not institution, give st | treet and number) | <u> </u> | | 9b. CITY | , TOWN C | R LOCATI | ON OF DE | | 9c. COL | JNTY OF DEA | TN | |
| 2 | St. Mary's Nursi | ng Center | <u> </u> | | Le | onar | dtow | n | | S | t. Mar | ry's | |
| 김 | | | | | | | ION | | | | L | Dd. INSIDE C | rity |
| 5 | | | | | hing | | | | | | | LIMITS? | |
| 7 | 10e. STREET AND NUMBER | <u>-</u> | | | | | . ZIP COD | | | 100 017 | | | _ |
| L L | 2501 Q Street, | | | | | 200 | | | U.S.A. | | | | |
| ם בי | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE W | YES 2 X | RMED NO | 5 | If yes, spe | ecity Cuba | | IIC ORIGIN? (Specify Yearn, Puerlo Ricen, etc.) | or No— | | American I White, etc. | , |
| ב ב | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5 + | - (i | Give kind of te. Do NOT u | work done | CCUPATIO during mo | ON st of workin | ימי | 16b, KIND OF BU | SINESS/IN | DUSTRY | | |
| | 12th Grade | | | Homen | aker | | | | Но | me | | | |
| 5 | 17. FATNER'S NAME (First, Middle, Last) | | | | | | 16. MOT | NER'S NA | ME (First, Middle, Maiden | Surname) | | | |
| ן נ | Francis Floy | d G | reenwel | 1 | | | Ма | rgar | et Bene | edict | Li | neham | 1 |
| | 19a. INFORMANT'S NAME (Type/Print) | | 1 | 9b. MAILING | ADDRES | S (Street a | nd Number | or Rural F | Route Number, City or Tow | n, State, Zi | p Code) | | |
| - | Rev. Francis Burc | h | | 5600 | City | Ave | nue, | Phi | ladelphia | Per | nsylv | ania | 1913: |
| | 20a. METNOD OF DISPOSITION 1 | oval from State | | ematory of o | | | | ugust | DATE 20c. LO | CATION — | VWOOd, | , stata Mary | land |
| | 21, SIGNATURE OF FUNERAL SERVICE LIC | Sar | liner |) | 22. Ma P. | NAME AN atti | ngle Box | ss of fa y-Ga: 270, | rdiner Fun Leonardto | eral wn, | Home Maryla | P.A. | • |
| | 23. PART / Entar the diseases, or condition IMMEDIATE CAUSE (Final disease or condition | List only one cau | t caused tha dise on each lin | 18. | | | | | | ratory sr | rrest, | | timate i Batweer and Dest |

Sequentially list conditions,
If any, leading to immediate cause. Enter UNDERLYING
CAUSE (Disease Dr injury that initisted events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY FIND

DESCRIPTION OF THE CONSEQUENCE OF):

24b. WERE AUTOPSY FIND

DESCRIPTION OF THE CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

24b. WERE AUTOPSY FIND

DESCRIPTION OF THE CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

On producing conditions contributing to death but not resulting in the underlying cause given in Part i.

24a. WAS AN AUTOPSY PERFORMED?

1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 YES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Thursting Name 5 Residence 6 DO

| L | | | | 28. PLACE OF DEATH (Ch | eck only one) |
|---|---|-------------|------------------|---|----------------------------------|
| | HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 | □ DOA | OTHE 4 I Nu | R: rsing Nome 5 - Residence | 8 Other (Specify) |
| | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIMI | E OF URY M | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE NOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At he building, etc. (Specify) | me, tarm, a | rfreet, fac | 26t. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

296. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year)

\$\frac{1}{3} \times \frac{1}{3} 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

John F. Fenwick, M.D. Leonardtown, Maryland 20650

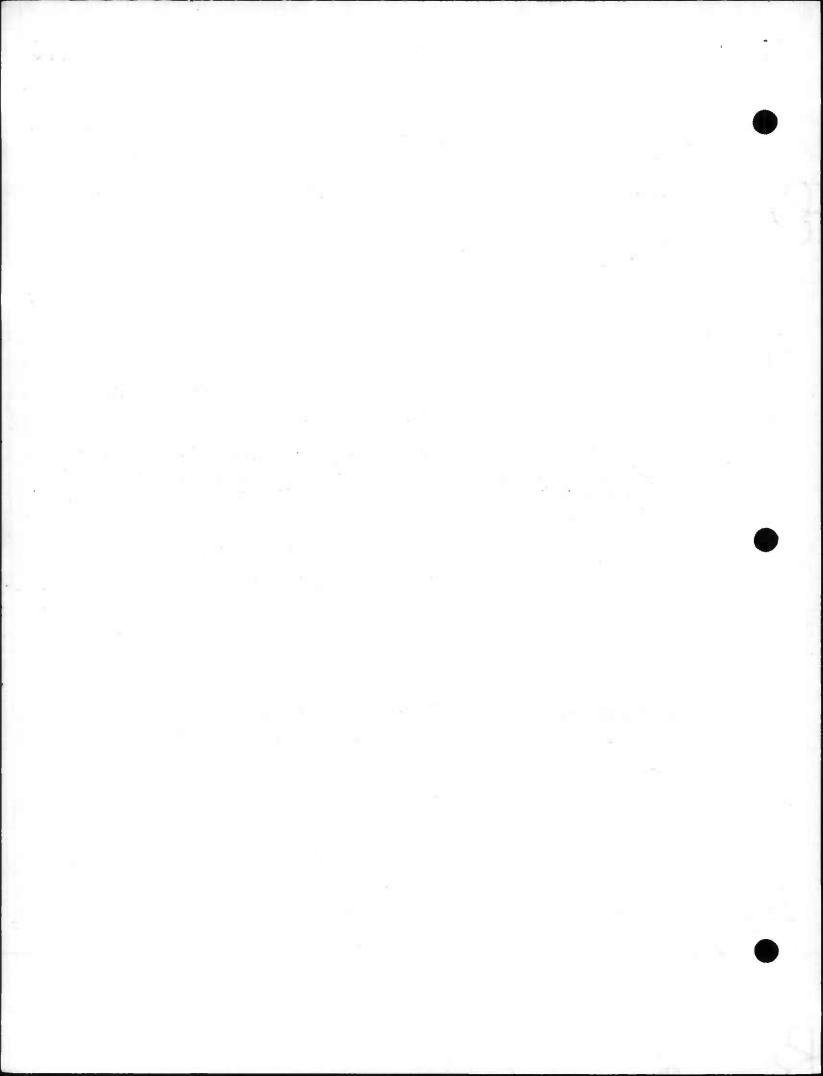
31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

D (MONITY, Day, Year)

32. REGISTRAR'S SIGNATURE

AUG 05 1994 Islin Dawidson Randall

DHMH-16 Rev 1/89



FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1 - REGISTRAR | | CERTI | FICATE O | DEATH | REG. NO | | | | | |
|---------------|--|--|--|---|---|--|-------------------------------|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Linst) Mary Magdeline | Э | Herbert | | | 2. DATE OF DEATH AUGUST 7, | | 3. TIME OF DEATH 1:45 A M | | | |
| | TAC TODAY TOTAL | | AGE (In yrs. last birthda) | MONTHS DAVE | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Feb 24, 18 | 1.0 | BIRTHPLACE (State or Foreign aryland | | | |
| TOR | 90. FACILITY NAME (If not institution, give stre St. Mary's Nursing | | | | or Location of Di ardtown | | 9c. COUNTY | | | | |
| DIRECTOR | 10e. STATE 10b. COUNTY Maryland St. Mai | ry's | 200 | eonardto | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | |
| FUNERAL | Star Rt. Box 4-A | | | | or. ZIP CODE 20650 | | U.S. | of what country? | | | |
| B | 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EV FORCES? 1 1 1 IF YES, GIVE WAR C | YES 2 X NO | If yes, | CENDENT OF HISPAI specify Cuban, Maxica S 2 NO Specif | NIC ORIGIN? (Specify Yes an, Puerto Rican, atc.) iy: | | RACE — American Indian, Black, White, etc. Soecily: BLack | | | |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade or Elementary/Secondary (0-12) | ATION ompleted) College (1-4 or 5+) | 16a. DECEDENT (Give kind of life. Do NOT Homema | 's usual occupa' If work done during in use retired.) iker | TION nost of working | 16b. KIND OF BUS | | RY | | | |
| BE CO! | 17. FATHER'S NAME (First, Middle, Last) William He | enry | Scriber | | 18. MOTHER'S NA Sophi | a Mari | _ | Cooper | | | |
| TO E | 190. INFORMANT'S NAME (Typo/Print) Mary Josephine Your | ng | 196. MAILH Star | Rt. Box | 4-A, Leo | Route Number, City or Tow nardtown, | n, Stere, Zip Cook Marylar | e) nd 20650 | | | |
| | 20a METHOD OF DISPOSITION 1 Surial 2 Cremation 3 Remov 4 Donation 5 Other (Specify) | al from State | 20b. PLACE AND DAT | | | 8/11/94 | cation - city Leonard | | | | |
| | 21. NAME AND ADDRESS OF FACILITY Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 | | | | | | | | | | |
| | 23. PART/1. Enter the diseases, or co- shock, or heart fellure. Li IMMEDIATE CAUSE (Finel disease or condition resulting in death) e. | lat only one ceuse of | on each line. | not enter the n | iode of dyling, suc | th as cerdiac or reap | iratory arrest, | Approximate interval Between Onset and Death | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | Sens oue to con anter | AS A CONSEQUENCE AS A CONSEQUENCE AS A CONSEQUENCE | -rc | Die Cod | 20 Vasc | ile | disease | | | |
| MEDICAL | PART II. Other algnificent conditions DID TOBACCO USE CO | | | | 20. | PERFOR | RMED? | 24b. WERE AUTOPSY FINOINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | HOSPITAL: | | | PLACE OF DEATH (Ch | | | | | | |
| HYSI | | 1 Inpetient 2 ER/ | | 4 Nursing Ho | me 5 Rasidence | 6 Other (Specify) 28d. 0ESCRIBE HOW I | N ILIBY OCCUPE | 20 | | | |
| BY P | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Ye | par) I | M 1 | YES 2 NO | | | | | | |
| ETED | 3 Suicide 6 Could not be determined | building, atc. | JURY — At home, farm (Specify) | , street, factory, of | ica | 281. LOCATION (Street a City or Town, State) | and Number or Re | ural Route Number, | | | |
| COMPLETED | | | | | | to the cause(s) and mer | | use(a) and manner as stated. | | | |
| 8 | 29b. SIGNATURE AND TITLE OF CERTIFIER | Em 1 | Q. | | D O | MBER 7 | 29d. DATE SIG | GNEO (Month, Day, Year) | | | |
| 임 | 30. NAME AND ADDRESS OF PERSON WHO YOUNGSIK MOON, M.I | | | | Maryland | 20636 | | | | | |
| | 31. DATE FILED (Month, Day, Year) ALIG 0 9 1994 | 32. REGISTRAR'S | SIGNATURE | | | | | | | | |

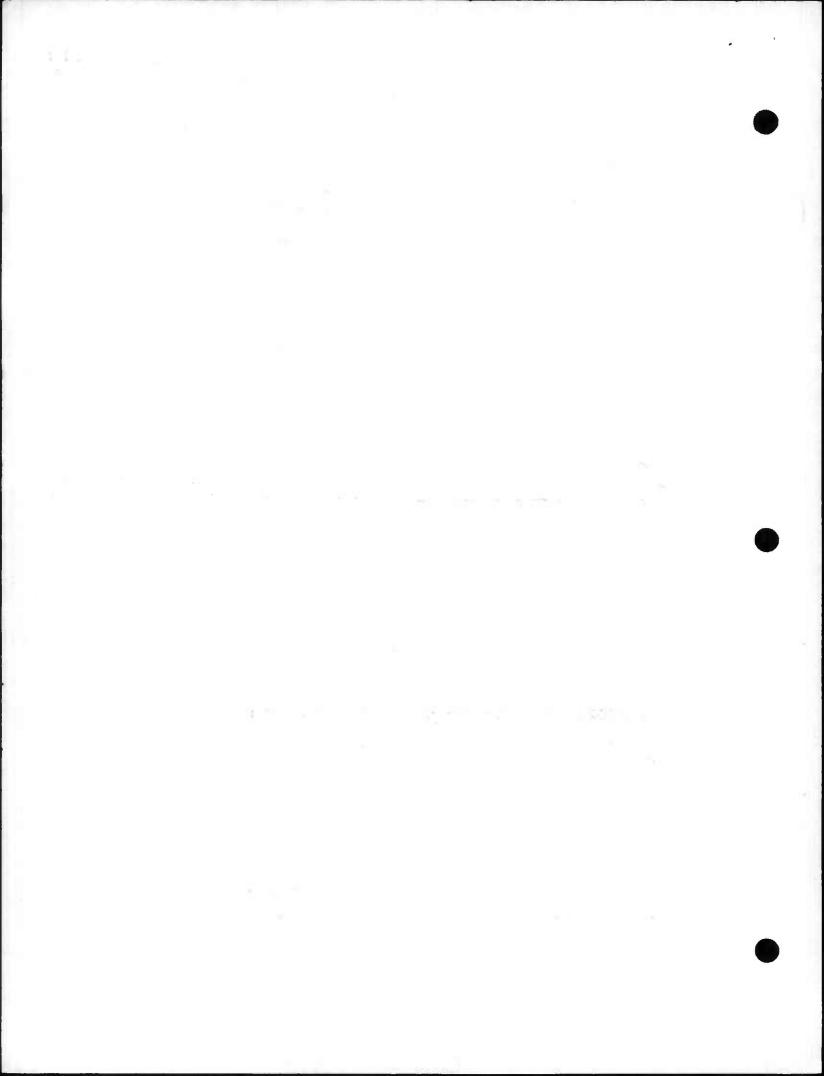
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Ours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trainst be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.



FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| 1. DECEDENT'S NAME (First, Middle, La | | | 10111 - 01 | DEATH | REG. | 110. | | | |
|---|--|--|--|--|--|--|--|--|--|
| | et) | | | | 2. DATE OF DEAT | | 3. TIME OF DEATH | | |
| RAYMOND | Bruce H | HOOVER | | | August | 23, 199 | 4 8:30 P. | | |
| 4. SOCIAL SECURITY NUMBER 217–10–2781 | | AGE (In yrs. lest birthday) 79 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS, HOURS MIN. | 7 DATE OF BIRTH | | BIRTHPLACE (State or Foreign Country) Pennsylvania | | |
| 9a. FACILITY NAME (If not institution, give | | | % city, town of Hagers | PR LOCATION OF DE | EATH | 9c. COUNTY | OF DEATH | | |
| RESIDENCE OF DECEDENT 10a. STATE 10b. COU | | I m. oc | TY, TOWN OR LOCAT | | | Washington | | | |
| Maryland Was | shington | | gerstown | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | |
| 100. STREET AND NUMBER 10731 Oak Forest | Drive | | 10f | 21740 | | | S.A. | | |
| 11. MARITAL STATUS 1 Never Merried 2 Married 3 Nidowed 4 Divorced | 12. WAS DECEDENT EV FORCES? 1 I | YES 2 NO | If yes, spi | ENDENT OF HISPAF ecify Cuban, Maxica 2 XNO Specifi | NIC ORIGIN? (Specifi in, Puerto Ricen, etc. y: | Yes or No— 14 | RACE — American Indian, Black, White, alc. Specify: White | | |
| 15. DECEDENT'S E (Specify only highest gri | DUCATION rade completed) | 16a. DECEDENT'S | S USUAL OCCUPATION work done during mosuse retired.) | iN st of working | 16b. KIND OF | BUSINESS/INDUS | TRY | | |
| Elementary/Secondary (0-12) 12 years | College (1-4 or 5+) | | use retired.) ce Office: | | Cit | y Govern | ent | | |
| 17. FATHER'S NAME (First, Middle, Lest) Raymond Winger | | | | | Me (First, Middle, Me Mae Bar | | | | |
| 190. INFORMANT'S NAME (Type/Print) Fran K. Hoover | | | Oak For | | | | | | |
| 20a. METHOD OF DISPOSITION 1 Sp Burlal 2 Cremation 3 R 4 Donation 8 Other (Specify) | emoval from State | 20b. PLACE AND DATE cemetery, crematory of ROSE HILL | OF DISPOSITION (Na other place) | me ol | OATE 200 | LOCATION — CIT | y or Town, State | | |
| 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE | NOSE IIIII | | | | | n Blvd. Nort | | |
| 23. PART I. Enter the diseases/ | H JUNI | W | Fune | ral Home | Hager | stown, M | laryland | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | b | AS A CONSEQUENCE OF AS A C | OF): | | | | | | |
| CAUSE (Disease or injury that initiated eventa | DUE TO (OR | AS A CONSCOURNCE (| OF): | | | | | | |
| | dtlons contributing to de | ath but not resulting | | cause given in | Part I. 24a. WA | 3 AN AUTOPSY | | | |
| that initiated eventa resulting in death) LAST | dtions contributing to dea | eth but not resulting | | | PEF | S AN AUTOPSY IFORMED? S 2 [X] NO | AVAILABLE PRIOR TO | | |
| that initiated eventa resulting in death) LAST PART ii. Other aignificent condit 25. WAS CASE REFERRED TO MEDICAL | d. Itom contributing to de- Directs h Convai | eth but not resulting | in the underlying | | 1 D YE | FORMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH? | | |
| that initiated eventa resulting in death) LAST PART ii. Other aignificent condit | d. January 10 der | ath but not resulting | in the underlying | ACE OF DEATH (Ch | 1 D YE | FORMED? | COMPLETION OF CAUSE OF DEATH? | | |
| PART (i. Other aignificent condit | HOSPITAL: 1 Inpatient 2 ER 28a. DATE OF INJ. (Month, Day, V | eth but not resulting | OTHER! | ACE OF DEATH (Ch | PEF 1 P YE | IFORMED? S 2 ⊠ NO | AMALABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO | | |
| PART II. Other significent condit | HOSPITAL: 1 Inpatient 2 ER 28e. DATE OF INJ (Month, Day, Y be | ath but not resulting Continue | OTHER: 4 Mursing Hom M 1 1 1 | ACE OF DEATH (Ch | PEF 1 YE 2 Other (Specify) 28d. DESCRIBE Hi | S 2 X NO DW INJURY OCCUP | AMALABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO | | |
| PART ii. Other significent condit 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Tatural 5 Pending Investigation 3 Suicide 8 Could not determined 29a. CERTIFIER (Check only) | HOSPITAL: 1 Inparient 2 ER 28a. DATE OF INJ (Month, Day, V be 1 28a. PLACE OF IN building, stc. | ath but not resulting | 28_PE OTHER: 4 Nursing Hom ME OF MUTHER: WO 1 1 N street, factory, office | ACE OF DEATH (Ch | eck only one) 8 Other (Specify) 28d. DESCRIBE Hi City or Town, S | S 2 X NO OW INJURY OCCUP Treet and Number or Nate) | AMAILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH? 1 YES 2 NO RED Rural Route Number, | | |
| PART ii. Other significent condit 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Tatural 5 Pending Investigation 3 Suicide 8 Could not determined 29a. CERTIFIER (Check only) | HOSPITAL: 1 Inpatient 2 ER 28a. DATE OF INJ MORITAN: To the best of my NIMER: On the best of examinating the series of examinating the serie | th but not resulting the but the property of t | OTHER: 4 Nursing Hom ME OF 28c. INJI JURY M 1 1 1 street, factory, office | ACE OF DEATH (Ch | PEF 1 YE 1 YE 28d. DESCRIBE HI 28l. LOCATION (St. City or Town, S. Cit | S 2 NO OW INJURY OCCUP Treet and Number or State) manner as stated, e, and due to the c | AMAILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH? 1 YES 2 NO RED Rural Route Number, | | |

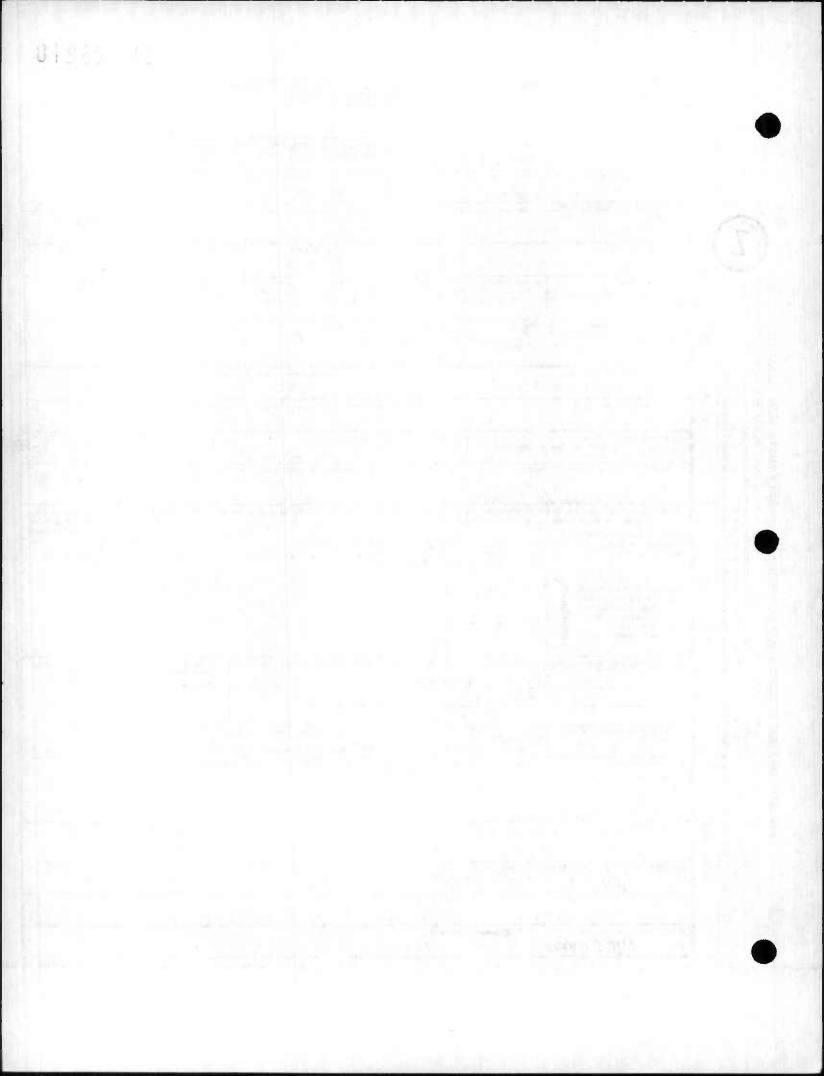
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Jours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the fundable filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

OHMH-16 Rev 1/89



| - 2 | REGISTRAR 1. DECEDENT'S NAME (First, Middle, L | .ast) | OLITIFIC. | CATE OF I | | REG. NO. | | 3. TIME OF DEATH | | | |
|---|--|--|---|---|--|--|---|--|--|--|--|
| 1 / | LENA | V. HOLLA | ND | | | 08 - 25- | 94 YEAR | 505 | | | |
| -1 | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | (In yrs. last birthday) | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRT | THPLACE (State or Fore | | | |
| | 9a. FACILITY NAME (If not institution, g | 1 M 2 F 8 | 7 YRS. | | | Apr. 8,19 | | aryland | | | |
| 8 | Colton Villa | n // | one | | stour | md | 9c. COUNTY OF | , | | | |
| 5 | RESIDENCE OF DECEDENT | A | | TOWN OR LOCATIO | | | | | | | |
| DIRECTOR | | shington | | erstown | LIM | | | | | | |
| 岩 | 10e. STREET AND NUMBER | | | | ZIP CODE | WHAT COUNTRY? | | | | | |
| FUNER | 7 E. Washingt | 21740 | | USA | | | | | | | |
| E E | 1 Never Married 2 Married | 12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D | NDENT OF HISPANIC city Cuban, Mexican, E X NO Specify: | ORIGIN? (Specify Yea of Puerto Rican, etc.) | Bla | CE — American Indiar ick, Whita, etc. | | | | | |
| р Ву | 3 Widowed 4 Divorced | | | | | | 354 | White | | | |
| ETED | 15. DECEDENT'S (Specify only highest of | EDUCATION grade completed) College (1-4 or 5 +) | (Give kind of wor life. Do NOT use if | k done during most | of working | 16b. KIND OF BUSI | NESS/INDUSTRY | | | | |
| COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | homema | aker | | home | | | | | |
| COM | 17. FATHER'S NAME (First, Middle, Last Norman Scott | _ | | | | (First, Middle, Maiden S | | | | | |
| 8 | 19a. INFORMANT'S NAME (Type/Print) | Tundey | 196. MAILING A | DDRESS (Street on | | lay Moor | | | | | |
| 2 | Rodney B. Hol | land | | ate Pal | | Vero Bea | | la. 3296 | | | |
| | 20a. METHOD OF DISPOSITION 1 [X]Burtal 2 Cremation 3 | | D. PLACE AND DATE OF | | | 1 | ATION — City or | | | | |
| | 1 (X Burtal 2 Cremation 3 Ramovel from Stata Representation of Control (Specify) Restaurance of Funeral Service Licensee 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | |
| | Gerald N. Minnich 305 N. Potomac S | | | | | | | | | | |
| | Funeral Home Hagerstown, Md. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | |
| | shock, or heart failura. List only one cause on each line. IMMEDIATE CAUSE (Final | | | | | | | | | | |
| | disease or condition resulting in death) | . POSSIBLE DUE TO (OR AS | RDIAL | INFA | | Peio i | | | | | |
| | | | | | | | | | | | |
| | | LEFT C | 12K1=13K | CVIT | | | | · | | | |
| ō | Sequentially list conditions, | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury CAUSE (Disease or Injury). | | | | | | | | | |
| ICATION | If any, leading to immediate | · ADULT | ONSET | | | | | 84EH | | | |
| TIFICATION | If any, leading to immediate cause. Enter UNDERLYING | C ADULT (| ONSET A CONSEQUENCE OF): | DIAB | | | | 81EM Loyear | | | |
| RTIFIC | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. HYPER | ONSET a consequence of): TEN TION | DIAB | e tes | MALLITU | | 81Em 20year 20year | | | |
| AL CERTIFIC | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | c. ADVLT (DUE TO (OR AS A J. H. P. E. C. Itions contributing to death by | ONSET A CONSEQUENCE OF; TEN TION Dut not resulting in | DIAB | e tes | MALLITU | UTOPSY 24 | 20 year 20 year MALLABLE PRIOR T | | | |
| AL CERTIFIC | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c. ADVLT (DUE TO (OR AS A J. H. P. E. C. Itions contributing to death by | ONSET a consequence of): TEN TION | DIAB | e tes | MALLTU | UTOPSY 24 | 20 Year 20 Hours 4b. WERE AUTOPSY FIN AMAILABLE PRIOR T COMPLETION OF CO OF DEATH? | | | |
| MEDICAL CERTIFIC | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c. ADVLT (DUE TO (OR AS A J. H. P. E. C. Itions contributing to death by | ONSET A CONSEQUENCE OF; TEN TION Dut not resulting in | DIAB | e tes | M ALLTU | UTOPSY 24 | 20 Year 20 Year 4b. WERE AUTOPSY FIN AMAILABLE PRIOR T COMPLETION OF CO OF DEATH? | | | |
| AN: MEDICAL CERTIFIC | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c. ADVLT (DUE TO (OR AS A d. 144PEC dilitions contributing to death by M | ON SET A CONSEQUENCE OF): TEN TION Dut not resulting in | DIAB The underlying 28. PLA | e tes | MALLTU art I. 24e. WAS AN A PERFORM 1 YES 2 | UTOPSY 24 | 20 Year 20 Year 4b. WERE AUTOPSY FIN AMAILABLE PRIOR T COMPLETION OF CA OF DEATH? | | | |
| SICIAN: MEDICAL CERTIFIC | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent cond 25. WAS CASE REFERRED TO MEDICAE EXAMINER? 1 YES 2 NO | c. ADVLT (DUE TO (OR AS A d. 1+V P[Z]C Iltions contributing to death b M HOSPITAL: 1 Inpetient 2 ER/Out | ON SET A CONSEQUENCE OF): TEN TON Dut not resulting in | the underlying 28. PLA THER: Nursing Home | CE OF DEATH (Check | art I. 24a. WAS AN A PERFORM 1 VES 2 CONTY One) | JUTOPSY 24 | 20 Year 20 Year 4b. WERE AUTOPSY FIN AMAILABLE PRIOR T COMPLETION OF CO OF DEATH? | | | |
| PHYSICIAN: MEDICAL CERTIFIC | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent cond 25. WAS CASE REFERRED TO MEDICAEXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending | c. ADVLT DUE TO (OR AS A) d. TYPEC Illions contributing to death b M HOSPITAL: 1 Inpatient 2 ER/Out (Month, Day, Yea) | ON SET A CONSCOUENCE OF): TEN TION Dut not resulting in A postlent 3 DOA 4 28b. TIMEA | the underlying 28. PLA OTHER: Nursing Home OF 28c. INJUINT WORK WORK WORK | CE OF DEATH (Check 5 Residence 6 RY AT 2 KY? | THE PROPERTY OF THE PROPERTY O | JUTOPSY 24 | 20 Year 20 Year 4b. WERE AUTOPSY FIN AMAILABLE PRIOR T COMPLETION OF CA OF DEATH? | | | |
| SICIAN: MEDICAL CERTIFIC | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent cond 25. WAS CASE REFERRED TO MEDICAE EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigat 3 Suicide 8 Could not | C. ADVLT DUE TO (OR AS I d. HVPZC Iltions contributing to death to AL HOSPITAL: 1 Inpetient 2 ER/Out (Month, Day, Yee) 25e. PLACE OF INJURY 25e. PLACE OF INJURY | DN SET A CONSEQUENCE OF): TEN TON Dut not resulting in A DOA 28b. TIME INJUS Y—At home, term, str | the underlying 28. PLA OTHER: Nursing Home Y WOR Q M 1 YE | ceuse given in Pa | TYPE 2 TO THE CONTROL OF THE CONTROL | JURY OCCURED | 20 year. 20 year. 4b. WERE AUTOPSY FIN AMAILABLE PRIOR TI COMPLETION OF CA OF DEATH? 1 YES 2 N | | | |
| ETED BY PHYSICIAN: MEDICAL CERTIFIC | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent cond 25. WAS CASE REFERRED TO MEDICAEXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigat | c. ADVLT DUE TO (OR AS // d. ITY PIZA d. ITY PIZA iltions contributing to death by AL HOSPITAL: 1 Inpatiant 2 ER/Out, (Month, Day, Way) 26a. PLACE OF INJURY building, etc. (Soe the | DN SET A CONSEQUENCE OF): TEN TON Dut not resulting in A DOA 28b. TIME INJUS Y—At home, term, str | the underlying 28. PLA OTHER: Nursing Home Y WOR Q M 1 YE | ceuse given in Pa | art I. 24a. WAS AN A PERFORM 1 VES 2 Conly one) Other (Specify) Red. DESCRIBE HOW IN. | JURY OCCURED | 1 □ VES 2 Ø N | | | |
| PLETED BY PHYSICIAN: MEDICAL CERTIFIC | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent cond 25. WAS CASE REFERRED TO MEDICAE EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigat 2 Accident 3 Suicide 8 Could not datarmine 29a. CERTIFIER (Check only) | c. ADVLT DUE TO (OR AS d. HYPER Itions contributing to death to AL HOSPITAL: 1 Inputter 2 ER/Out (Month, Day, Year) 26a. PLACE OF INJURY building, etc. (Spe | DNSET A CONSEQUENCE OF): TENTION Dut not resulting in Postlant 3 DOA 2 Postlant 3 DOA 2 Postlant 3 DOA 3 Postlant 3 DOA 4 Postlant 3 DOA 6 Postlant 4 DOA 6 Postlant 4 DOA 6 Postlant 5 DOA 6 Postlant 6 DOA 6 Postlant 7 DOA 6 Postlant 7 DOA 6 Postlant 8 | the underlying 28. PLA OTHER: Nursing Home OF 28c. INJUIT WOR M 1 VE set, factory, offica | CE OF DEATH (Check 5 Reeldence 6 RY AT K? ES 2 NO | art I. 24a. WAS AN A PERFORM 1 VES 2 J T Only One) Other (Specify) 18d. DESCRIBE HOW IN. Only Or Town, State) N / the cause(a) and manner. | JURY OCCURED ad Number or Rura oer as stated. | 20 Year. 20 Year. 4b. WERE AUTOPSY FIN AMAILABLE PRIOR T COMPLETTOR 1 YES 2 No. | | | |
| PLETED BY PHYSICIAN: MEDICAL CERTIFIC | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent cond 25. WAS CASE REFERRED TO MEDICAE EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigat 2 Accident 3 Suicide 8 Could not datarmine 29a. CERTIFIER (Check only) | C. ADVLT DUE TO (OR AS A d. HOPITAL: 1 Inpetient 2 ER/Out AL HOSPITAL: 1 Inpetient 2 ER/Out (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Spe | DNSET A CONSEQUENCE OF): TENTION Dut not resulting in Postlant 3 DOA 2 Postlant 3 DOA 2 Postlant 3 DOA 3 Postlant 3 DOA 4 Postlant 3 DOA 6 Postlant 4 DOA 6 Postlant 4 DOA 6 Postlant 5 DOA 6 Postlant 6 DOA 6 Postlant 7 DOA 6 Postlant 7 DOA 6 Postlant 8 | the underlying 28. PLA OTHER: Nursing Home OF 28c. INJUIT WOR M 1 VE set, factory, offica | CE OF DEATH (Check 5 Reeldence 6 RY AT K? ES 2 NO | art I. 24a. WAS AN A PERFORM 1 VES 2 J T Only One) Other (Specify) 18d. DESCRIBE HOW IN. Only Or Town, State) N / the cause(a) and manner. | JURY OCCURED ad Number or Rura oer as stated. | 20 Years 20 Years 4b. WERE AUTOPSY FIN AMAILABLE PRIOR TI COMPLETOR 1 YES 2 No. | | | |
| PLETED BY PHYSICIAN: MEDICAL CERTIFIC | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent cond 25. WAS CASE REFERRED TO MEDICAE EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigat 2 Accident 3 Suicide 8 Could not datarmine 29a. CERTIFIER (Check only) | aL HOSPITAL: HOSPITAL: Inpetient 2 ER/Out Month, Day, Yeer) See PLACE OF INJURY (Month, Day, Yeer) See Date of Injury building, etc. (Spe | DNSET A CONSEQUENCE OF): TENTION Dut not resulting in Postlant 3 DOA 2 Postlant 3 DOA 2 Postlant 3 DOA 3 Postlant 3 DOA 4 Postlant 3 DOA 6 Postlant 4 DOA 6 Postlant 4 DOA 6 Postlant 5 DOA 6 Postlant 6 DOA 6 Postlant 7 DOA 6 Postlant 7 DOA 6 Postlant 8 | the underlying 28. PLA THER: Nursing Home OF 28c. INJUI YOU YOU YOU YOU YOU YOU YOU YOU YOU YOU | CE OF DEATH (Check 5 Reeldence 6 RY AT K? ES 2 NO | art I. 24s. WAS AN A PERFORM 1 VES 2 TO THE CONTROL OF THE CALL O | JURY OCCURED Id Number or Rura Idea as stated. Idea to the cause | 20 Years 20 Years 4b. WERE AUTOPSY FIN AMAILABLE PRIOR TI COMPLETOR 1 YES 2 No. | | | |
| E COMPLETED BY PHYSICIAN: MEDICAL CERTIFIC | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent cond 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 | DUE TO (OR AS A LINE TO | DN SET A CONSEQUENCE OF): TEN TON Dut not resulting in A petiant 3 DOA 4 28b. TIME INJURY Y— At home, term, structive On and/or investigation, | the underlying 28. PLA DTHER: Nursing Home OF Y 28c. INJUIL WOR J T T T T T T T T T T T T T T T T T T | CE OF DEATH (Check S Residence 6 RY AT 2 KY 2 NO 2 and pleas, and due to sith occured at the tire | art I. 24s. WAS AN A PERFORM 1 VES 2 TO THE CONTROL OF THE CALL O | JURY OCCURED Id Number or Rura Idea as stated. Idea to the cause | DOYEAU | | | |
| BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFIC | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent cond 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 | aL HOSPITAL: HOSPITAL: Inpetient 2 ER/Out Month, Day, Yeer) See PLACE OF INJURY (Month, Day, Yeer) See Date of Injury building, etc. (Spe | DN SET A CONSEQUENCE OF): TEN TON Dut not resulting in A perlant 3 DOA 4 28b. TIME INJURY Y At home, term, structive N/A viedga, death occurred on and/or investigation, EATH (ITEM 27) (Type, P. | the underlying 28. PLA OTHER: Nursing Home OF WOR M 1 Ye eet, factory, office at the time, date a in my opinion, des | CE OF DEATH (Check of the state | art I. 24s. WAS AN A PERFORM 1 VES 2 TO THE CONTROL OF THE CALL O | JURY OCCURED JURY OCCURED and Number or Rure and the cause 29d. DATE SIGNE 8 2 | DOYEAU DOYEAU DOYEAU AD. WERE AUTOPSY FIN AMAILABLE PRIOR T COMPLETION OF CA OF DEATH? 1 YES 2 No. | | | |

A CONTRACTOR CONTRACTOR KINGSON SAN

BALTIMORE, MARYLAND 21215-0020

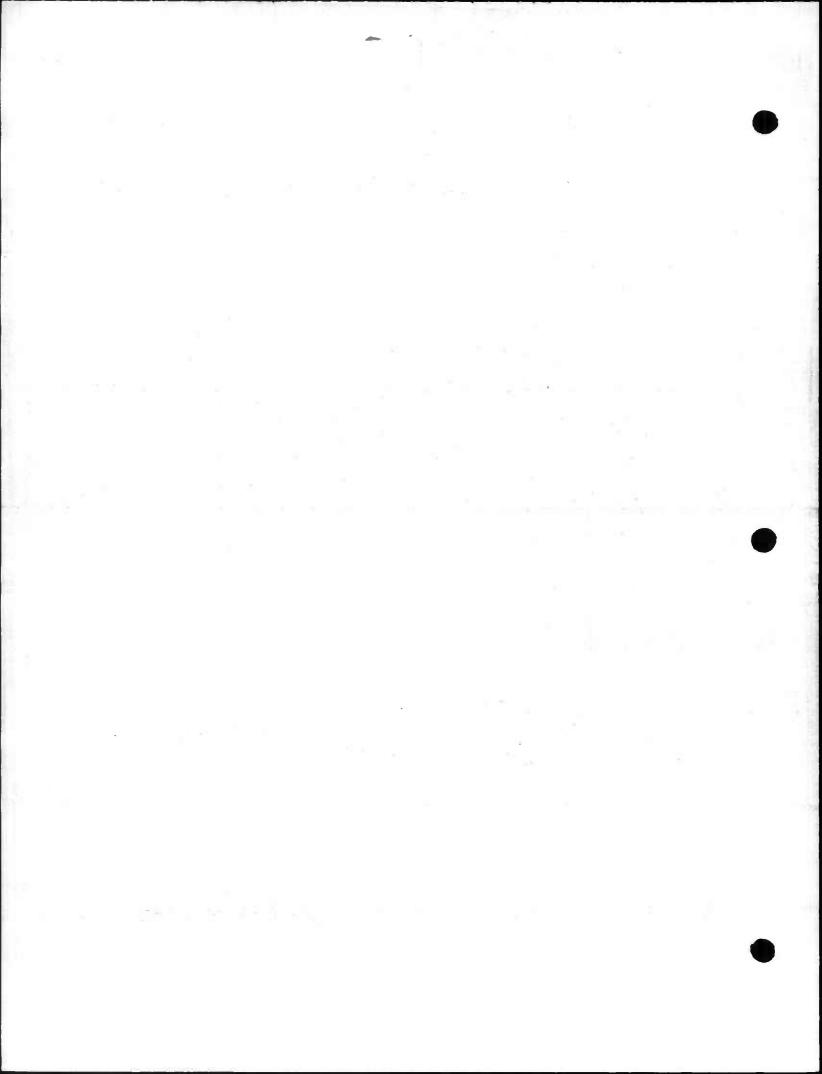
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriak-transit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPART | | | MENTA | L HYGIEN | E | | | |
|------------------|---|--|---|--|---|---------------------------------|-----------------------------------|---|----------------------|--------------|----------|
| | 1. OECEDENT'S NAME (First, Middle, Last) | | | | | | OF DEATH | | | OF DEATH | |
| 1 | ERNEST 4. SOCIAL SECURITY NUMBER 5. | ARNO | TD . | UTCHII | NSON IF UNDER 24 HRS, | - | GUST 2 | 0 199 | | | Ам |
| | 040 66 -046 | | | ONTHS DAYS | HOURS MIN. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) 3-7-1954 Maryland | | | | | ign | |
| - | 9e. FACILITY NAME (If not institution, give street | and number) | | 9b. CITY, TOWN | OR LOCATION OF D | | | 9c. COUNTY | | | |
| TOF | calvert memoria | l hospita | 1 | PRIN | INCE FREDERICK CALVERT | | | | | | |
| DIRECTOR | Maryland Prince | George¹ | 1 s Brandywine | | | | | 10d. INSIDE CITY LIMITS? 1 Ures 24 | | | 0 |
| FUNERAL | 100. STREET AND NUMBER]0601 Cross Road | | | f. ZIP CODE 20613 | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | |
| BY | 1 Never Merried 2 Married | U.S. ARMED 2 X NO | If yes, s | CENDENT OF HISPA pecify Cuban, Maxic 3 24 NO Speci | an, Puerto | N? (Specify Yaa Rican, etc.) | | RACE — Arme Black, Whita, Specify: Vnite | rican Indian etc. | | |
| COMPLETED | | DN pleted) Dilege (1-4 or 5+) | 16a. DECEDENT'S U (Give kind of wo life. Do NOT use Auto Me | rk done during m retired.) | ost of working | | P.G. (| | | | |
| E COM | 17. FATHER'S NAME (First, Middle, Last) William Frederic | | | _ | 16. MOTHER'S NA | AME (First, | | Sumame) | · | tchi | son |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) Sara D. Hutchiso | n | | | and Number or Rural S Road | | | | | 206 Md | 13 |
| | 20e. METHOD OF OISPOSITION **Y Burlal 2 Cremation 3 Removal 4 Donation 5 Other (Specify) | 20b | PLACE AND DATE OF etery, cremetory or other SUTTECT | DISPOSITION (N | ame of | DAT | TE 20c. LOC | CATION — City | or Town, State | | \dashv |
| | 21. BIGHATURE OF FUNERAL SERVICE LICENSE | Mark B | cohawn | 22. NAME A | NO ADDRESS OF FA | 'une | ral Ho | ome, | Inc. | | \dashv |
| | 23. PART I. Enter the diseeses, or comp | olications that caused | | P.O. | Box 15 | 6, | Waldon | cf, Mo | 1. 20 | | |
| | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, abock, or haert feliure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition presulting in death) Arteriosclerotic Cardiovascular Disease | | | | | | | | | | ween |
| CERTIFICATION | Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| AL | PART II. Other algnificant conditions co | ntributing to deeth b | ut not resulting in | the underlyin | g ceuse given in | Part i. | 24a, WAS AN PERFOR | MEO? | | LE PRIOR TO | |
| PHYSICIAN: MEDIC | | | | | <u> </u> | | 1 TYES 2 | Λ | OF OEAT | | |
| N. | DID TOBACCO USE CONTRIBU | | | | UNCERTAI | Ν□ | INQU | IRY | X | S 2 NO | |
| Si C | | SPITAL: | | OTHER: | | | | | | | _ |
| HYS | 27. MANNER OF DEATH | 28a. DATE OF INJURY | atient 3 DOA 4 | | ne 5 🗆 Rasidence | | or (Specify) SCRIBE HOW IN | LIIIRY OCCUR | ED. | | |
| ВУ Р | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJUI | M 1 | PRK7 YES 2 NO | 100.00 | | | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28a. PLACE OF INJURY building, etc. (Spec | — At homa, farm, str | eet, factory, offic | • | 28f. LOC City | CATION (Street a. or Town, State) | nd Number or R | lural Route Num | nber, | |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: 2 X MEDICAL EXAMINER: On | | | | | | | | use(s) and ma | nner ea stat | ed. |
| H | 296. SIGNATURE AND TITLE OF CERTIFIER Would H | hight MD | | | 29c. LICENSE NUI | | | 29d. DATE SIG | GNED (Month, I | | 94 |
| 임 | DOLALD G. WRIGHT | | ATH (ITEM 27) (Type, P 111 Pen | | | | | | | | |
| | 31. OATE FILED (Month, Day, Year) AUG 2 6 1994 | 22 DECISTRADIS SICAL | TURE RANGEL | | *** | | | | | | |
| | HUU & U 1994] | U | | | | _ | - | | | DHMH-16 F | |



| DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020 | |
|---|--------|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within cours after death. Page 6 may be retained by the hospital or attending physician | , |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trainst permit be filled within 72 hours after death with the State Debt. of Health and Mental Hydiene prior to burial, cremation, or removal. | med po |
| IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | .ed |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

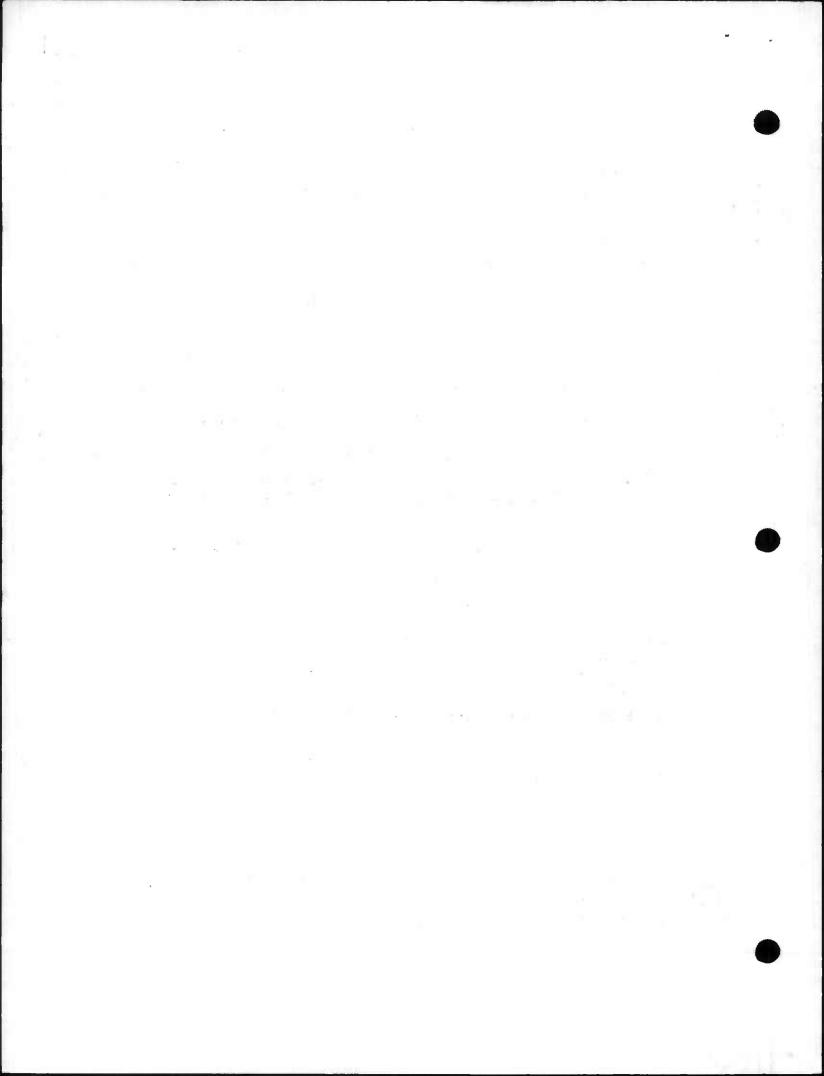
CERTIFICATE OF DEATH

REG. NO.

2. DATE OF DEATH

| | 1. DECEDENT'S NAME (First, | Middle, Last) | | | | | | | | 2. DATE OF DEATH | | | 3. TIME OF DEAT | н |
|---------------|--|--------------------------|---------------------|--------------------------------------|--------------|--|------------|----------------------|-----------------|---|-----------------------------|-----------|----------------------------------|--------------|
| | Rosine | Cece | elia | | Hodg | es | | | | July 24, | 1994 | YEAR | 11:25 | Рм |
| | 4. SOCIAL SECURITY NUMB | | 5. SEX | 6. AGE (In yrs. last | birthday) | IF UNDER | | _IF UNDER | | 7. DATE OF BIRTH | | 8. BIRTI | HPLACE (State or Fo | |
| | 212-54-1034 | | 1 🗌 M 2 📡 F | 84 | YRS, | MONTHS | DAYS | HOURS | MIN. | Oct 6, 19 | 09 | Was | hington, | D.C |
| | 9e. FACILITY NAME (If not in | stitution, give s | treet and number) | | | 9b. CITY | , TOWN | OR LOCATI | ON OF DE | | | INTY OF C | | |
| 8 | St. Mary's | Hospit | al | | | Le | onai | rdtow | m | | St | . Ma | ary's | |
| 5 | RESIDENCE OF DEC | 10b. COUNTY | | | | | | 100 | | | | | | = |
| DIRECTOR | Maryland | | Mary's | | | ioc. city, town or location Leonardtown | | | | | 10d. INSIDE CITY LIMITS? | - 1 | | |
| | 10e. STREET AND NUMBER | 50. | raty s | | Le | CITAL | | | | | 1 | | 1 YES 2 | NO |
| RA | Star Rt. Box | 66 | | | | | 101 | 2065 | | | | .S.A | WHAT COUNTRY? | |
| FUNERAL | 11. MARITAL STATUS | | 12. WAS DECEDED | T EVER IN U.S. ARI | MED | 13 | WAS DEC | | | IC ORIGIN? (Specify Yes | | | • E — American India | |
| | 1 Never Married 2 Merried FORCES? 1 YES 2 X | | | | | | l1 yes, sp | | n, Mexical | n, Puerto Ricen, etc.) | O 140— | | k, White, etc. | in, |
| B | 3 🔀 Widowed 4 🗌 Divo | rced | | THE CHILDRICA | | | | 2 (2) 110 | эрвспу | | | Whi | | |
| COMPLETED | | EDENT'S EDU | | 16a. DE(| CEDENT'S | USUAL O | CCUPATIO | ON ast of working | na | 16b. KIND OF BUS | SINESS/IN | DUSTRY | | |
| | Elementary/Secondary (0 | -12) | College (1-4 or 5 | +) ///e. | Do NOT us | e retired.) | | | | 770000 | | | | |
| MP | | | years | I III | omema | rker | | | | Home | | | | |
| | 17. FATHER'S NAME (First, M. Henry | Fran | ocie | LaFon | -aine | | | | DUISE | ME (First, Middle, Maiden May | | ears | | |
| BE | 190. INFORMANT'S NAME (7) | | 1015 | | | | 0.00 | | | Route Number, City or Tow | | | | |
| 5 | Virginia Lo | | lodges | | | | | | | ata, Md. 2 | | p Code) | | |
| | 20a. METHOD OF DISPOSITION 12 Buriel 2 Cremetic 4 Donation 5 Other | n 3 🗆 Reme | oval from State | 20b. PLACE A cemetery, cree | matani or of | thor place! | | | 7/2 | DATE 20c. LO 27/94 Val | | | | , |
| | 21. NGNATORY OF FUNERAL | | ENSEE/ | - 50. 00 | OT GE | 22. | NAME A | ND ADDRE | SS OF FAC | CILITY | | | | 1 |
| | 22. NAME AND ADDRESS OF FACILITY Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 | | | | | | | | | | | | | |
| | 23. PART . Enter the diseases, of complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory erreat, Approximate | | | | | | | | | | | | | |
| | snock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | |
| , | disease or condition resulting in death) a. Acuts becurrent Cerebro Vascula Acuts | | | | | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditi | | b. DUE TO | (OR AS A CONSEC | LIENCE OF | D. | | | | | | | - | |
| Ä | if any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | - 1 | | | |
| F | CAUSE (Disease or Inju that initiated events | | DUE TO | (OR AS A CONSEC | UENCE OF | 7): | | | | | | | | |
| 토 | resulting In death) LAST | | | | | | | | | | | | | |
| | PART II. Other significa | nt condition | a contributing to | death but not r | eultina I | n the us | darlula | | | Part I. 24a, WAS AN | | I all | | |
| EDICAL | Droles | 1 | 1/12 | | 1 | 1 | derlyin | T Cause (| Jiven in | PERFOR | | 248 | AWAILABLE PRIOR COMPLETION OF | 70 |
| | 2-200 | uo | prov | us | - 2 | 17 | The same | den | 24 | 1 TYES 2 | KNO | | OF DEATH? | |
| Σ | DID TOBACCO | LISE C | ONITRIBILITE | TO CALLS | E 0E | DEAT | u v | EC 🗆 | NO | <u> </u> | / | | 1 YES 2 | 10 |
| AN | 25. WAS CASE REFERRED TO | | CIVIKIBUIE | 10 CA03 | E OF | DEAT | | ES | NO EATH (Che | ick only one) | | | | |
| SIC | EXAMINER? | | HOSPITAL: | ER/Outpatient 3 | Nona | OTHE | ₹: | | | | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | | 28e. DATE OF | INJURY | 28b. TIM | E OF | 28c. INJ | URY AT | reidence | 6 Other (Specify) 28d. DESCRIBE HOW II | NJURY OC | CURED | | = |
| ВУ Р | | Pending Investigation | (Month, L | Jay, Year) | INJ | URY | | PRK? YES 2 | NO | | | | | |
| | 3 Sulaida | Could not be | 28e. PLACE (| OF INJURY — At hor atc. (Specify) | ne, 1erm, e | treet, fact | ory, offic | | | 281. LOCATION (Street | and Numbe | or Rural | Route Number, | |
| COMPLETED | 4 Homicide | determined | - Sunday | ata: jopocnyy | | | | | | City or Town, State) | | | | |
| PLE | 29e. CERTIFIER (Check only 1 CERT | IFYING PHYSI | CIAN: To the best o | ł my knowledga, dei | ith occurre | d at the t | lme, date | end place | , end due | to the cause(e) end mer | mer as at | rted. | | |
| O | one) 2 MEDI | CAL EXAMINE | R: On the basis of | xamination and/or i | rvestigatio | n, In my o | pinlon, d | leath occur | red at the | time, date end place, an | d due to t | he cause(| e) end menner ee s | inted, |
| BE C | 29b. SIGNATURE AND TITLE | OF CENTIFIES | A | | | | - | 29c. LICE | ENSE NUN | BER | 29d. DA | TE SIONE | (Mogth, Day, Year) | |
| | D19917 > 7/25/94 | | | | | | | | | | | | | |
| ٩ | The state of the s | | | | | | | | | | | | | |
| | | yd, M. | |) | | Le | onai | rdtow | m, M | Maryland 2 | 20650 |) | | |
| | JUL 26 | 1994 | REGISTRA | ARS SIGNATORE | U, | | | | | | | | | |
| | 001 40 | .001 | 4 | | | | | | | | | | | |

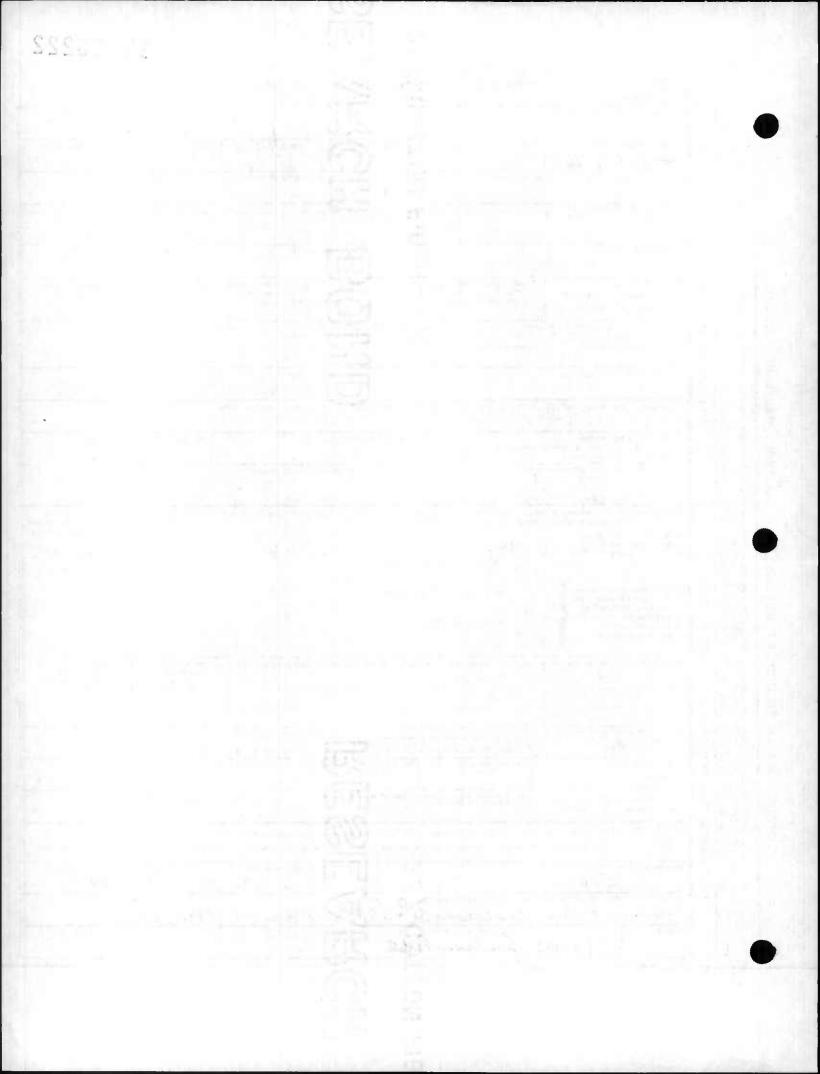
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the fours after death. Page 6 may be retained by the brooking physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. Amended Item #4

1 - STATE
REGISTRATE WCHD mpt 8/19/94 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| 1. DECEDENT'S NAME (First, Middle, Last) | | | | CALE | | | | | REG. NO. | | | |
|--|--|---|---|--|---|--|--|---|---|--|----------------------------|--|
| EVA MESSIC | K INSLE | Y | | 2 | エ | VSLE | Y | 2. DATE OF MONTH AUG-U | DAY | 7 19 | YEAR 9 4 | 3. TIME OF DEATH |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last | birthday) | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF | BIRTH | | | PLACE (State or Foreign |
| +2 218-16-7090 | 1 □ M 2 📉 F | 69 | YRS. | MONTHS | DAYS | HOURS | MIN. | 12/2 | 719: | 24 | | yland |
| Se. FACILITY NAME (If not institution, give s | street and number) | | | 9b. CITY, | TOWN (| R LOCATIO | N OF DEA | TH | | 9c. COU | NTY OF D | EATH |
| PENINSULA REGIONA | AL MEDICA | L_CENTER | | S | ALIS | BURY | | | | WI | COMI | CO |
| 10a. STATE 10b. COUNT | Υ | | 18c. CITY, TOWN OR LOCATION | | | | | | 10d, INSIDE CITY | | | |
| | omico | | Bivalve | | | | | LIMITS? | | | | |
| 100. STREET AND NUMBER 3993 Tex | as Road | | | | | | | U.S. | A . | | | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE W | T EVER IN U.S. ARN YES 2 AND AR OR DATES | If yes, specify Cuban, Maxican, Puerto Rican, etc.) | | | | or No- 14. RACE — American Indian, Black, White, atc. Specify: White | | | | | |
| 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 16a. DEC | EDENT'S | USUAL OC | CUPATIO | ON st of working | , | 16b, KII | ND OF BUSI | NESS/INI | DUSTRY | |
| Elementary/Secondary (0-12) | College (1-4 or 5 | Rin I | Do NOT us | e retired.) | | Wife | | 0. | wn H | ome | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 11001 | | _ | | E (First, Midd | | | | |
| Richard Messi | ck | | | -IN | 31 | M | lagg | ie C | ouch | | | |
| 19a. INFORMANT'S NAME (Type/Print) Harold L. Ins | ley | | | | | | | Biva | | | | 914 |
| 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | novel from State | 20b. PLACE AI cemetery, crem B1 V 3 | ND DATE O | her place) | TION (Na | me of erv | 8 | /2.2 | Biv: | | City or To | |
| 21. SIGNATURE OF FUNERAL DETIVICE LI | сенрек | | , | 22. N | AME A | D ADDRES | S OF FACE | ILITY | | | | |
| (omely | MIL | 0-417/ | Messick Funeral Home, P.O. Bivalve, Maryland 21814 deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, | | | | | | Box 61 | | | |
| resulting in death) Sequentially list conditions, | (OR AS A CONSECU | UENCE OF | j: j: | | | | | | | | months | |
| if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO | (OII AS A CONSEC | | | | | | | | | | |
| If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | d, | | eaulting i | n the und | deriyin | g ceuse g | iven in P | | e. WAS AN A PERFORM | ED? | 24b. | WERE AUTOPSY FINDING AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | d, | | eulting i | n the und | | | | _ 1 | PERFORM | ED? | 24b. | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant condition | d to a contributing to HOSPITAL: | death but not re | | OTHER | 26. PL | ACE OF DE | EATH (Chec | 1 | PERFORM | ED? | 24b. | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending | d to a contributing to HOSPITAL: | death but not re | | OTHER 4 Nursi | 26. PL l: lng Hom 28c. INJ WO | ACE OF DE | EATH (Chec | _ 1 | PERFORM VES 2 | NO NO | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 A NO 27. MANNER OF DEATH | HOSPITAL: 1) Inpatient 2 [28a. DATE OF (Month, D) 26a. PLACE O | death but not re | DOA 26b. TIME | OTHER 4 Nursi | 26. PL ing Hom 28c. INJ WO | ACE OF DE • 5 Rei | EATH (Checosidence 6 | 1 Other (S) 28d. DESCR | PERFORM VES 2 | NO NO | CURED | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| If arry, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only) | HOSPITAL: 1) I Inpatient 2 [28a. DATE OF (Month, D 26a. PLACE O building. | death but not re ER/Outpetient 3 (INJURY ay, Year) F INJURY — At hometc. (Specify) my knowledge, dea | DOA 26b. Tilet INJI | OTHER 4 Nursi E OF URY M Intreet, factor | 26. PL l: ling Hom 28c. INJ WO 1 1 7 | ACE OF DE 5 | NO NO and due to | isk only one) Other (S) 28d. DESCR 28f. LOCATIC City or 1 | PERFORM VES 2 j | NO NO NO NO NO NO NO NO NO NO NO NO NO N | r or Rural R | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| If arry, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: 1) Inpatient 2 28e. DATE OF (Month, D 26a. PLACE 0 building, | ER/Outpetient 3 (INJURY — At home etc. (Specify) my knowledge, dea xamination and/or in | DOA 26b. Tilet INJI | OTHER 4 Nursi E OF URY M Intreet, factor | 26. PL l: ling Hom 28c. INJ WO 1 1 7 | ACE OF DE e 5 Rei URY AT RK? ES 2 and place, eath occurr | NO and due to dat the til | Other (S 28d. DESCR 28f. LOCATII City or I | PERFORM VES 2 j | JURY OC | cured are fed, he cause(a) | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| If any, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: 1) Inpatient 2 26a. DATE OF (Month, D 26a. PLACE O building, ICIAN: To the best of a | death but not re ER/Outpatient 3 (INJURY as, Year) FINJURY — At hometc. (Specify) my knowledge, dea xamination and/or in | DOA 28b. TIMI INJI ne, farm, s | OTHER 4 Nursi E OF URY M Attreet, facto | 26. PL l: ling Hom 28c. INJ WO 1 1 7 | ACE OF DE e 5 Rei URY AT RK? ES 2 and place, eath occurr | NO and due to dat the til | Other (S 28d. DESCR 28f. LOCATII City or I | PERFORM VES 2 j | JURY OC | cured are fed, he cause(a) | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Noute Number, |
| If any, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINITY | HOSPITAL: 1) I Inpatient 2 E 28a. DATE OF (Month, D 26a. PLACE O building. ICIAN: To the best of a | death but not re ER/Outpatient 3 (INJURY as, Year) FINJURY — At hometc. (Specify) my knowledge, dea xamination and/or in | DOA 28b. TIMI INJI ne, farm, s | OTHER 4 Nume E OF URY M intreet, factor | 26. Pt i: lng Hom 28c. INJ WC 1 Dry, offic me, dete | ACE OF DE | and due to date to the state of | Other (S) 28d. DESCR 28d. LOCATIC City or 7 | PERFORM VES 2 j pecily) IBE HOW IN. ON (Street and own, State) a) and manned place, and | JURY OC JURY OC A Number Jury OC A Number Jury OC J | r or Rural R | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Noute Number, |
| If arry, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | HOSPITAL: 1) Impattent 2 28a. DATE Of (Month, D 26a. PLACE O building. ICIAN: To the best of a | death but not re ER/Outpatient 3 (INJURY as, Year) FINJURY — At hometc. (Specify) my knowledge, dea xamination and/or in | DOA 28b. TiMil INJI ne, farm, s th occurre restigation | OTHER 4 Nume E OF URY M intreet, factor | 26. Pt i: lng Hom 28c. INJ WC 1 Dry, offic me, dete | ACE OF DE e 5 Rei URY AT RK? ES 2 and place, eath occurr | and due to date to the state of | Other (S) 28d. DESCR 28d. LOCATIC City or 7 | PERFORM VES 2 j pecily) IBE HOW IN. ON (Street and own, State) a) and manned place, and | JURY OC | r or Rural R | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Noute Number, |

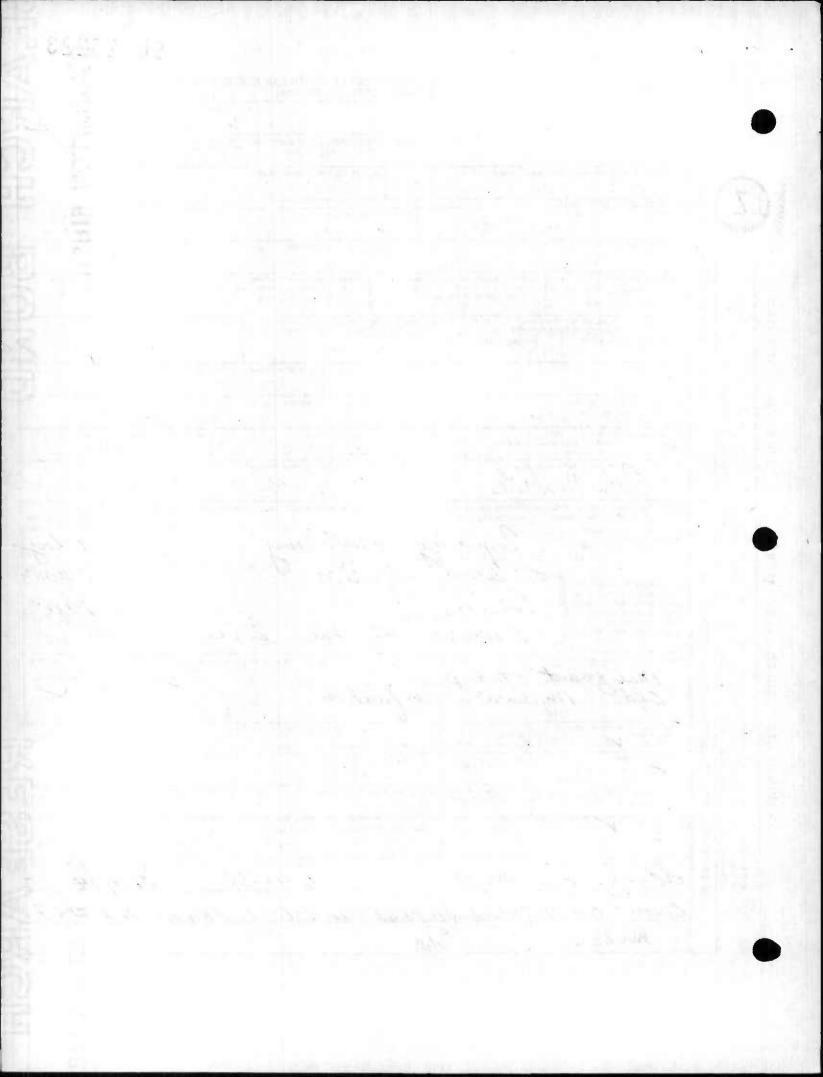


BALTIMORE, MARYLAND 21215-0020 F TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Abours after death. Page 6 may be retained by the burshing physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| | FOR | |
|---|-----------|--|
| 1 | STATE | |
| | REGISTRAR | |

| 1. DECEDENT'S NAME (Firs | t, Middle, Last) | | | | ICATE OF | | | REG. NO 2. DATE OF DEATH MONTH DO | | YEAR | 3. TIME OF DEATH |
|--|--|--|--|--------------------------------------|--|-----------------|----------------|---|------------------|---------------------------|---|
| Emma Loui | se Joh | nson | | | | | | MONTH D | | 34 | 435 A |
| 4. SOCIAL SECURITY NUM | | 5. SEX | 6. AGE (In yrs. | last birthday) | IF UNDER 1 YEAR | IF UNDER 2 | | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTHP Country | PLACE (State or Foreign |
| 219-20-4540 | | 1 M 2/CXF | 67 | YRS. | MONTHS DAYS | HOURS | Mint. | 12/28/26 | | | yland |
| 9s. FACILITY NAME (If not it | | | | | 9b. CITY, TOWN | OR LOCATION | OF DE | ATH | 9c, COU | INTY OF DE | ATH |
| Carroll Cou | | neral Ho | spital | | Westmi | nster | | | Cai | rrol1 | |
| RESIDENCE OF DE | | Y | . 1 | 10c CIT | Y, TOWN OR LOCA | TION | | | 10d, INSIDE CITY | | |
| ML | Ca | CARRO | 11 | | aneytown | | | | | | LIMITS? |
| 10e. STREET AND NUMBER | | LLIK | | | - | r. ZIP CODE | _ | | 1 44 - 017 | | 1 YES 2 NO |
| 4234 Franc | | LL Var. II | i oder mer | | | 2178 | 7 | | 10g. CI1 | U.S | |
| 11. MARITAL STATUS | 15 500 | 12. WAS DECEDEN | | ARMED | 12 WAS DE | | | IC OBICIND (Seconds No. | as Na | | |
| | 1 Never Merried 2 Merried 3 Widowed 4 Divorced FORCES? 1 YES, GIVE WAR O | | | 25 NO If yes, specify Cuben, Maxicon | | | | n, Puerto Rican, atc.) | 0 NO_ | Bleck, Specify Whit | |
| | CEDENT'S EDU | | 16a. | DECEDENT'S | USUAL OCCUPAT | ON | | 16b. KIND OF BUS | SINESS/INI | DUSTRY | |
| Elementary/Secondary (| | College (1-4 or 5 | | Itte. Do NOT u | | ust or worlding | | | | | |
| 10 | | | P | Assemb | ly Work | | | Electr | ical | Hard | ware |
| 17. FATHER'S NAME (First, A | Aiddle, Last) | | | | | | | ME (First, Middle, Meiden | Sumame) | | |
| Theodore H | | | | | | Vi | o1a | Green | | | |
| 190. INFORMANT'S NAME (| ** | | | 19b. MAILING | AODRESS (Street | and Number o | r Rural F | Noute Number, City or Tow | n, State, Zij | p Code) | ELECTION |
| George D. | Johns | on | | 4234 | F.S.K. H | IWY. | Tane | eytown, MD | | | The same |
| 20a. METHOD OF DISPOSIT | on 3 🗆 Rem | oval from State | 20b.PLAC | CE AND DATE | of disposition (N | Inno C | Ωm | | | boro, | |
| 4 Donetion 5 Other | | CENGEE A | | | | ND ADDRESS | | | UUUS! | 0010, | MD |
| 11 1 | 1 | Theter | | | | | | 1 Home, 13 21787 | 6 E. | Balt | imore St. |
| 23. PART Enter the cahock, or h | diseases, or maart fallure. | complications the | it caused tha | death. Do i | not enter the m | ode of dyin | g, sucl | as cardiac or respi | ratory ar | resi, | Approximate Interval Between |
| IMMEDIATE CAUSE (FI disease or condition resulting in death) | → nat | a. Resp | nato | y 1 | insuff | icieu | 4 | | | | Onset and Dea |
| Sequentially list conditions to imme | | Ple | COR AS A COM | el | Jusi or | 1. (| 1 | | | | 1 mon |
| Sequentially list condi- if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or Inju- that inlitted events resulting in death) LAS | diate ING ury | c. Due to | und | SEQUENCE O | fuel o | n. C | † | l'ver | | | 1 mon |
| if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or inju- that initieted events | ediate PING ury ST | DUE TO DUE TO d. C. SM | OF AS A COMMON SON OF AS A COMMO | SEQUENCE O | Fusion A | | J. ven In | Pert I. 24a. WAS AN PERFOR | RMED? | | WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| If any, leading to imme cause. Enter UNDERLY CAUSE (Disease Dr Injuithat initiated events resulting in death) LASPART II. Other significations of the cause of th | ent condition | DUE TO C. DUE TO DUE TO DUE TO A. C. SM The contributing to The co | O (OR AS A CONTACT OF A CONTACT | SEQUENCE O | F): In the underlyle arch or 28. F | | | PERFOF | RMED? | | COMPLETION OF CAUSE OF DEATH? |
| If any, leading to imme cause. Enter UNDERLY CAUSE (Disease or injusted in interest in the int | ent condition | c. Due To Due To Due To d. C. M as contributing to | O (OR AS A CONTACT OF A CONTACT | SEQUENCE O | Fi: In the underlyle Arch or 28. F | g cause gl | ATH (Che | PERFOF | RMED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or injithat initiated eventa resulting in death) LAS PART II. Other significations of the cause of t | ediate ing series in series ing series ing series ing series ing series ing series in | DUE TO DUE TO DUE TO DUE TO DUE TO A HOSPITAL: 1 Uninpetent 2 26e. DATE Of | OR AS A CONTROL OF THE PROPERTY OF THE PROPERT | SEQUENCE O | F): In the underlyle 28. P OTHER: 4 Nursing Hot URY W | g cause gl | ATH (Che | PERFOR | EMED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| If any, leading to imme cause. Enter UNDERLY CAUSE (Disease or Injithat Initiated events resulting in death) LAS PART II. Other signification of the cause of th | ent condition | DUE TO C. DUE TO DUE TO DUE TO DUE TO A STATE OF THE COMMONT. I. 280. PLACE OF THE COMMONT. I. | O (OR AS A CONTINUE OF THE PRIVATE O | SEQUENCE OF RESUlting | F): In the underlyle 28. P OTHER: 4 Nursing Hot URY W | PLACE OF DEJ | ATH (Che | PERFOR 1 YES 2 ack only one) 6 Other (Specify) | NJURY OC | CCURED | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| If any, leading to imme cause. Enter UNDERLY CAUSE (Disease or Injithat Initiated events resulting in death) LAS PART II. Other algnific. 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Natural 6 2 27. Accident 2 Accident 3 Suicide 6 4 Homicide 29s. CERTIFIER (Check only) | ent condition ant condition ant condition ant condition and pending investigation Could not be determined | DUE TO | GOR AS A CONTROL OF INJURY — At etc. (Specify) | SEQUENCE O | The underlying the un | PLACE OF DEJ | ATH (Che | PERFOR 1 YES 2 ack only one) 6 Other (Specify) 28d. OESCRIBE HOW I 281. LOCATION (Street | NJURY OC | COURED or or Rural Ro | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| If any, leading to imme cause. Enter UNDERLY CAUSE (Disease or Injithat Initiated events resulting in death) LAS PART II. Other algnific. 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Natural 6 2 29. CERTIFIER (Check only) 29s. CERTIFIER 1 CER | ent condition ant condition August FO MEDICAL Pending Investigation Could not be determined TIFYING PHYS DICAL EXAMINE | DUE TO DU | GOR AS A CONTROL OF INJURY — At etc. (Specify) | SEQUENCE O | The underlying the un | PLACE OF DEA | ATH (Che dence | PERFOR 1 YES 2 beck only one) 6 Other (Specify) 28d. OESCRIBE HOW I 281. LOCATION (Street City or Town, Stele) 10 the cause(a) and main time, date end place, and | NJURY OC | or or Rural Ro | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| If any, leading to imme cause. Enter UNDERLY CAUSE (Disease or injithat initiated eventa resulting in death) LAS PART II. Other signification in the cause of th | ent condition ant condition August FO MEDICAL Pending Investigation Could not be determined TIFYING PHYS DICAL EXAMINE | DUE TO DU | OR AS A CONTROL OF INJURY — At. etc. (Specify) | SEQUENCE O | The underlying the un | PLACE OF DEJ | ATH (Che dence | PERFOR 1 YES 2 beck only one) 6 Other (Specify) 28d. OESCRIBE HOW I 281. LOCATION (Street City or Town, Stele) 10 the cause(a) and main time, date end place, and | NJURY OC | or or Rural Ro | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |



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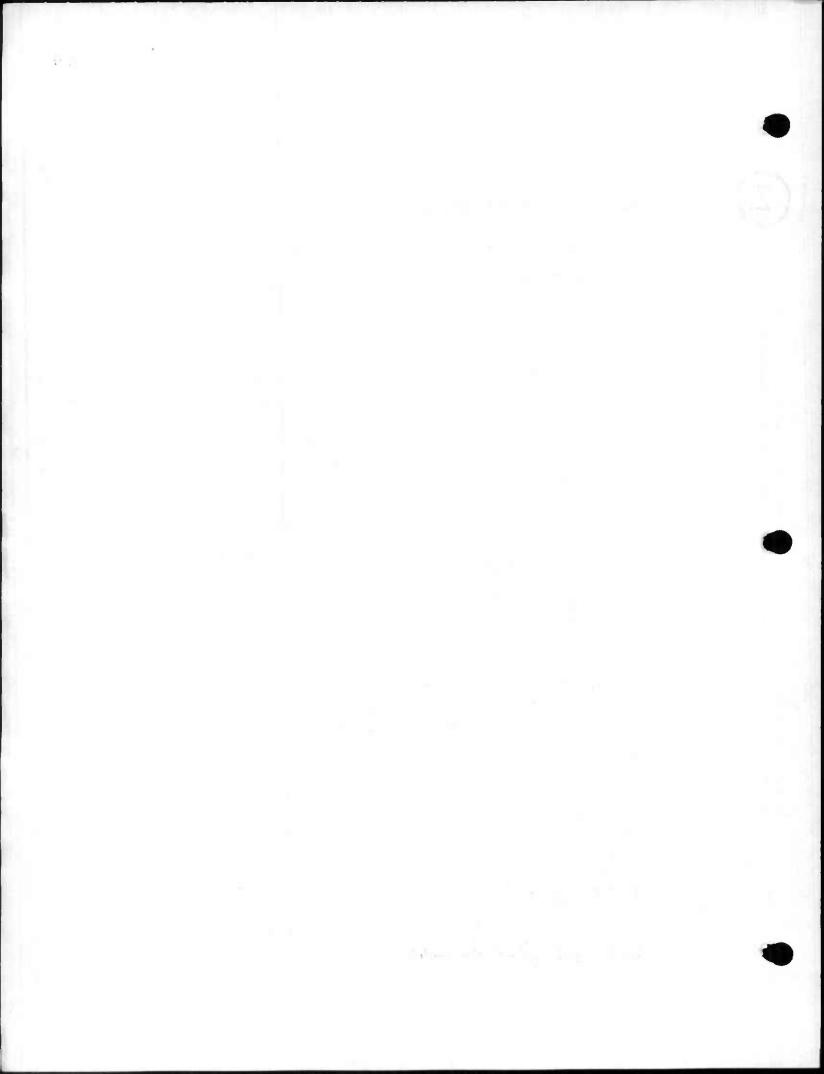
| examin | |
|--|--|
| medical | |
| the | |
| event, | |
| IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examin | FICATION |
| other | E |
| 9 | 1 65 |
| injury, | A C |
| any | SIC |
| shows | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICAT |
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|----------------------|---|---|--|--|--|------------------|--|--|--|
| | 1 - STATE REGISTRAR | STATE OF MARYLAND / | DEPARTMEN ERTIFICAT | T OF HEALTH AND I | | _ | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) 1. DOLL LEST 4. SOCIAL SECURITY NUMBER 5 | 50165 . SEX 6. AGE (In yrs. las | t birthday) IF UNDE YRS. MONTHS | R 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN. V, TOWN OR LOCATION OF DE | REG. NO 2. DATE OF DEATH MONTH 7. DATE OF BHITN (Month, Day, Year) 16-25-19// | S. B. | IRTNPLACE (State or Foreign ountry) ALJLAND | | |
| DIRECTOR | MANSEN NU | KSING HOME | 17 | ANNE | EAIN | 5000 | ELSET | | |
| | 104. STATE 106. COUNTY Som R 106. STREET AND NUMBER | CLSEF | 10c. CITY TOWN | ANNE | MARYLA | Nd. | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | |
| FUNERAL | 11427- BRAFE | EN AVE | MED / Lo | 2/853 | (| u | S A | | |
| ВУ | 1 Never Merried 2 Merried 3 1 Widowed 4 Divorced | FORCES? 1 YES 2 IN IF YES, GIVE WAR OR DATES | 10 | WAS DECENDENT OF NISPAN If yee, specify Cuben, Maxice 1 YES 2 NO Specify | n, Puerto Rican, atc.) | 8 | RACE — American Indian, Black, White, etc. | | |
| COMPLETED | | npleted) (Gh | CEDENT'S USUAL Of the kind of work done Do NOT use retired.) | during most of working | 166. KIND OF BUS | 1 | WRS 52 | | |
| BE CO | 17. FATNER'S NAME (First, Middle, Last) BENYIMIN | 1001067 | NE | 505A1 | | MINE | | | |
| 5 | 190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Bural Route Number, City of Jown, State, Zip Code) 11437 BLAHEN AVE HE ANNE Md. 21853 200. METHOD DE DISPOSITION 200. METHOD DE DISPOSITION 200. PLACE AND DATE OF DISPOSITION (Name of Town State) | | | | | | | | |
| | 200. MET BUT OF DE JUST OF THE STATE OF THE | from State | Hattury or other places | CH CEMATA | 4 /20 GRI | ERN We | of PL. ANNE | | |
| 9 | · Rusell- | faik- | 1 | NAME AND ADDRESS OF FAC | Salish | ISA | 6211A St Md. 21881 | | |
| | 23. PART I. Entar the diseases, or com abock, or heart failure. List IMMEDIATE CAUSE (Final disease or condition reaulting in death) | plications that caused the dest only one cause on each line. Av terror DUE TO (OR AS A CONSEO | | the mode of dying, such | | (| Approximate interval Between Onset and Death | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST | DUE TO (OR AS A CONSECU | | DIS | | | | | |
| PHYSICIAN: MEDICAL (| PART II. Other algorificant conditions of | entributing to deeth but not rever 140at 17 Fibrulla; | tions trace | derlying cause given in i | Part I. 24a. WAS AN PERFORI | MED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO CDMPLETION DF CAUSE OF DEATH? 1 YES 2 AND | | |
| YSICI | 1 YES 2 NO 1 | OSPITAL: Inpatient 2 ER/Outpatient 3 | DOA 4 Run | 26. PLACE OF DEATN (Che | | | | | |
| BY | 27. MANNER OF DEATN 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE NOW IN | JURY OCCURED | | | |
| TED | 3 Suicide 8 Could not be determined | 28e. PLACE OF INJURY — At hom building, etc. (Specify) | ne, farm, atreat, fact | ory, affice | 28f. LOCATION (Street ar City or Town, State) | nd Number or Run | al Route Number, | | |

29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and mi

31. DATE FILED (Month, Day, Year) AUG 22 1994

32 REGISTRAR'S BIGNATURE



| DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-00 | TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with chours after death. Page 6 may be retained by the hospital or attending pl | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the by the filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notifiled at once. |
|---|---|---|---|
| - VITAL | ICIAN: The lar | ertificate has the State Deg | or item 23 |
| ON OF | DING PHYS. | After this c | s marked. |
| DIVISI | DR ATTEN | DIRECTOR: hours after | tem 28 1 |
| _ | HOSPITAL | FUNERAL WITHIN 72 ! | ANT: If I |

| | 1 - STATE REGISTRAR | STATE OF MARYLAND | / DEPARTMENT | OF HEALTH AND | MENTAL HYGIE | | | |
|------------------|---|--|---|--|---------------------------|---------------------------------------|---|----------|
| 9 | 1. DECEDENT'S NAME (First, Middle, Last) | 1 | +, | | 2. DATE OF DEATH | DAY YE | 3. TIME OF DEATH | |
| | 4. SOCIAL SECURITY NUMBER | S. SEX 6. AGE (In yrs. I. | | YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | 3 1994 | BIRTHPLACE (State or Foreig | M |
| 4 | 266-76-5099 | 1 - M 2 X F 50 | | DAYS HOURS MIN. | MARCH | 237 | FL. | |
| œ | 90. FACILITY NAME (If not institution, give : PENTINGITA DECT | street and number) ONAL MEDICAL CEN | | OWN OR LOCATION OF D | EATH | 9c. COUNTY | | |
| 010 | RESIDENCE OF DECEDENT | | | SALISBURY | | MTCC | OMICO | |
| DIRECTOR | 10e. STATE 10b. COUNT | comico | 10c. CITY, TOWN OR | LOCATION | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| | 10. STREET AND NUMBER | | JOHODE | 101. ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? | \dashv |
| FUNERAL | ad Catheri | 12. WAS DECEDENT EVER IN U.S. A | IDMED 12 W | 21801 | NIC OBIOING (Co | Un | S, A. | _ |
| | Never Merried 2 Merried 3 Widowed 4 Divorced | FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | NO If | res, specify Cuban, Mexic YES 2 W NO Specify NO | en, Puarto Rican, etc.) | | RACE — American Indian, Black, White, etc. Specify: | , |
| D BY | 15. DECEDENT'S EDU | UCATION 16a (| DECEDENT'S USUAL OCC | TIDATION | 165 KIND OF E | USINESS/INDUST | Dlack | |
| COMPLETED | (Specify only highest grade Elementary/Secondary (0-12) | e completed) | (Give kind of work done during the Do NOT use retired.) | ring most of working | 100. KIND OF E | , / | н | |
| MP | 17. FATHER'S NAME (First, Middle, Last) | UNKNOWN | Domeste | _ | 1501 | tel . | | \dashv |
| BE CC | JOSEPH HOWA | and | | 18. MOTHER'S N. | AME (First, Middle, Maid | Stine | | |
| TO B | 184. DECREAME S NAME (7/04/FINE) | 10.00 | 96. MAILING ADDRESS | Street and Number or Rural | Ploute Number, City, or 1 | own, State, Zip Coo | 71 | \dashv |
| | METHOD OF DISPOSITION | 2010/201 AC | E AND DATE OF DISPOSITI | history H | re-/von | OIT VI | 7 | _ |
| | Buriel 2 Cremetion 3 Rem | noval from State | tematory or other process | S | 876 3 | alisbu | ry, MD | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSER | 22. N/ | AME AND AGORESS OF FA | CILITY FOOK | Funer | all Service | |
| | Thurse | 4. Tooks | 191 | 7 W. Ls | abella S | + Salu | a, MD 2180 | 0/ |
| | | complications that ceused the c List only one cause on sech lin | ieath. Do not enter the na. | he mode of dying, suc | ch as cardiac or rea | piratory arrest, | Approximate interval Betwood Onset and D | reen |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) | · CANDI | P44401 | TARY AL | vest | | 4724 | |
| | | | EOUENCE OF): | Heman | 24060 | | . * | |
| NO I | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A CONS | EOUENCE OF): | [/0 - 00 4 | -costa | · · · · · · · · · · · · · · · · · · · | | |
| 2 | cause. Enter UNDERLYING CAUSE (Disease or injury | c. DUE TO (OR AS A CONS. | FOLIENCE OF | | | | | |
| CERTIFICATION | that initiated eventa resulting in death) LAST | d | EODENCE OF). | | | | | |
| AL CE | PART II. Other significent condition | ns contributing to deeth but not | resulting in the und | erlying ceuee given in | Part 1. 24a. WAS | AN AUTOPSY | 24b. WERE AUTOPSY FINDI | NGS |
| | LINER FAIL | ure | | | PERF | ORMEO? | AVAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? | BE |
| ME ME | | | | | | | 1 TES 2 NO | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PLACE OF DEATH (C | heck anly one) | | | \dashv |
| YSIC | EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpetient 2 ER/Outpetient | 3 DOA OTHER: | ng Home 5 🗆 Residence | 6 Other (Specify) | | | |
| | 27. MANNER OF DEATH 1 Netural 5 Pending | 28s. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF 2 | Bc. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOV | V INJURY OCCURE | ED | |
| D BY | 2 Accident Investigation 3 Suicide 6 Could not be | 26e. PLACE OF INJURY — At I building, etc. (Specify) | nome, ferm, street, factor | | 261. LOCATION (Street | | tural Route Number, | - |
| ETED | 4 Homicide determined | saliding, etc. (opocity) | | | City or Town, Ste | (0) | | |
| COMPLET | | SICIAN: To the best of my knowledge, of ER: On the bests of examination and/o | | | | | and the second | |
| | 29b. SIGNATURE AND TITLE OF CHITTEE | | Threshigation, in my opi | 29c. LICENSE NU | | | GNED (Month, Day, Year) | d. |
| TO BE | Juli W. Je | et 1 | up | D 194 | 132 | ▶ & | 13/44 | |
| ۴ | 30 NAME AND AGORESS OF BERISON WI | COMPLETED MUSE OF DEATH (IT | EM 27) (Type, Print) | 1. 2 | 1110 | () | MOS | 0 |
| | 31. DATE FILED (Month, Day, Year) | 232. REGISTRAR'S SIGNATURE | Mous | we or | 402 | SILVE | Eug MOZ | py |
| 1 | AUG 22 1994 | your dander hards | 4 | | | | / | |

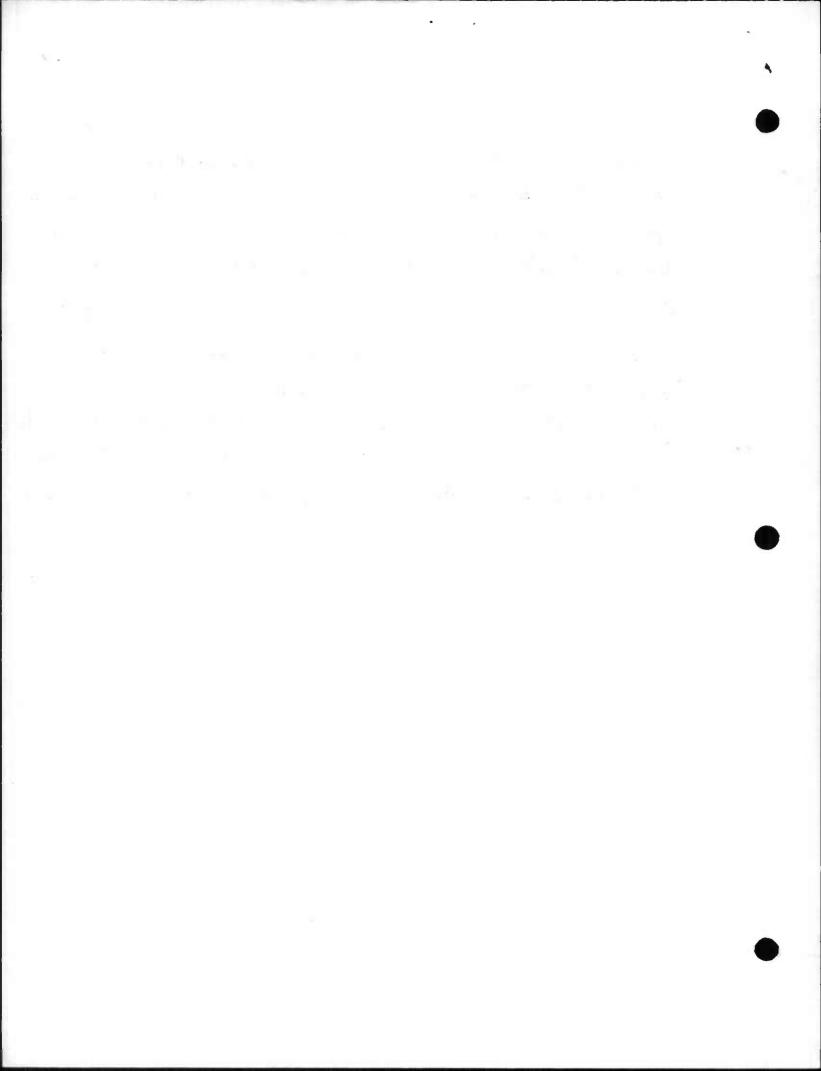
firmed of Josha 917 W. Isabella St-Sulva, MD 21801

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

| 4 hours after death. Page 6 may be retained by the hospital or attending physician. | filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. | n, or remova. The medical examiner must be notified at once | |
|---|--|--|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. | De lifet writin /z Hours aret death with the state Uspt, of regain and mental hypters provide builds, crematon, or removal. IMPORTANT: If them 28 is marked, or them 23 shows any injury, or other traumatic event, the medical examiner must be notified at once | |

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR CERTIFICATE OF DEATH REG. NO. |
|-------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH |
| | LILLIE M. JOHNSON AUGUST 19, 1994 11.05 AM M |
| | |
| | BUTTON OF BIRTH TEAM FUNDER THAN TO SHEET BIRTH B. BIRTHPLACE (SIGN OF PORIGIN |
| | 218-24-6111 1 M 2 XF 94 YRS. MONTHS DAYS HOURS MIN. 05-11-1900 VIRGINIO |
| | |
| - | |
| 10 | PRINCE George Hospital Cheverly PRINCE George |
| 15 | RESIDENCE OF DECEDENT |
| DIRECTOR | 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY |
| = | LA U LA LA LA LA LA LA LA LA LA LA LA LA LA |
| | 10100101 |
| A | 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? |
| FUNERAL | 5507 Toding MOUNT 2/8/64 1/64 |
| Z | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBED OF HISDANIC ORIGINA (Specific Vision Mo.) 14. PAGE A Purious (salar) |
| 교 | FORCES 4 Ven a Mark To Provide Children (Specify tea of No. 1 NACE — American Indian, |
| ₽ | 1 Never Merried 2 Merried 2 Merried IF YES 2 NO Specify: |
| | 3 Wildowed 4 Divorced |
| 0 | 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION 16s. KIND OF BUSINESS/INDUSTRY |
| E | (Specify only nignest grade completed) (Give kind of work done during most of working the Dr. NOT use period) |
| 1 5 | College (1-4 of 5+) |
| 탈 | 6 Domestic Housework |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Symame) |
| | STEPHEN JOHNSON MARY TAYLOC |
| HB | |
| | 196. INFORMANT'S NAME (Type/Print) . 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
| 임 | Sarah Coleman 1504 Shadu Glen DR. District Hites and |
| | 1001 011844 01-1 1031116-112 |
| | 1 Suriel 2 Cremetion 3 Removal trom State Committee Comm |
| 1 1 | 4 Donation 5 Other (Specify) Home Sen, Fich 8-2594 Stockton, Incl. |
| 1 1 | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22, NAME AND ADDRESS, OF FACILITY |
| 1 1 | WHARTON FUNDING HOME |
| | Reich Eile Marton 22/7/ wholeton Rd. Accomac Vg. |
| | AN INDICATE A CANADA CONTRACTOR OF THE CONTRACTO |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. Approximate interval Between |
| 1 1 | IMMEDIATE CAUSE (Final Onset and Death |
| | disease or condition Congestive heart failure leart |
| 1 1 | DUE TO (OR AS A CONSEQUENCE OF): |
| | |
| Z | Sequentially list appellions The Ischemic cardiomyopathy years |
| | Sequentially list conditions, If any, leading to immediate |
| | cause. Enter UNDERLYING |
| 1 1 1 | CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): |
| lēl | that initiated evens resulting in death) LAST |
| CERTIFICATION | d |
| 0 | |
| 4 | PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? ANALABLE PRIOR TO |
| DICAL | COMPLETION OF CAUSE |
| 0 | |
| Σ | OSTED MYELLAS FIGHT ankle |
| I 45 1 | |
| | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES TO NO TO UNCERTAIN TO |
| | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 1 |
| | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: |
| | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 28. PLACE OF DEATH (Check only ons) OTHER: 4 Nursing Home 5 Reeldence 6 Other (Specify) |
| | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outpatient 3 DOA 28. DATE OF INJURY 28. DATE OF INJURY 28. DATE OF INJURY 28. DESCRIBE HOW INJURY OCCURED |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 NO |
| | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO |
| D BY PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 28. PLACE OF DEATH (Check only one) 1 Norther: 1 Norther of DEATH 1 Netural: 28. DATE OF INJURY (Month, Day, 'Ver) 29b. Time of Injury (Month |
| ED BY PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 3 Suicides |
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| ED BY PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. DATE OF INJURY 1 Netural 27. MANNER OF DEATH 1 Netural 28. DATE OF INJURY 1 Nonth, Day, Year) 28. DATE OF INJURY (Month, Day, Year) 28. PLACE OF INJURY (Month, Day, Year) 28. PLACE OF INJURY (Month, Day, Year) 28. PLACE OF INJURY (Month, Day, Year) 28. PLACE OF INJURY (Month, Day, Year) 28. PLACE OF INJURY At home, Ierm, atreet, factory, office 28. PLACE OF INJURY 28. PLACE OF INJURY At home, Ierm, atreet, factory, office 28. PLACE OF INJURY 28. PLACE OF INJURY At home, Ierm, atreet, factory, office 28. PLACE OF INJURY 28. PLACE OF INJURY 28. PLACE OF INJURY At home, Ierm, atreet, factory, office 28. PLACE OF INJURY City or Town, State) |
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| E COMPLETED BY PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. Place OF DEATH (Check only one) 27. MANNER OF DEATH 1 Netural 2 Pending Investigation 3 Suicide 4 North, Dey, Year) 28. Place OF INJURY (Month, Dey, Year) 28. Place OF INJURY (Month, Dey, Year) 28. Place OF INJURY (Month, Dey, Year) 28. Place OF INJURY (Month, Dey, Year) 28. Place OF INJURY (Month, Dey, Year) 28. Place OF INJURY (Month, Dey, Year) 28. Place OF INJURY (Month, Dey, Year) 28. Place OF INJURY (Month, Dey, Year) 28. Place OF INJURY (Month, Dey, Year) 28. Place OF INJURY (Month, Dey, Year) 28. Place OF INJURY (Month, Dey, Year) 28. Place OF INJURY (Month, Dey, Year) 28. Place OF INJURY (Month, Dey, Year) 28. Place OF INJURY (Month, Dey, Year) 28. Place OF DEATH (Check only one) 28. Place OF INJURY (Month, Dey, Year) 28. Place OF INJURY (Month, Dey, Year) 28. Place OF INJURY (Month, Dey, Year) 28. Place OF INJURY (Month, Dey, Year) 28. Place OF INJURY (Month, Dey, Year) 28. Place OF INJURY (Month, Dey, Year) 28. Place OF INJURY (Month, Dey, Year) 28. Place OF INJURY (Month, Dey, Year) |
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| E COMPLETED BY PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 1 Netural 28. DATE OF INJURY (Month, Day, Year) 28. DATE OF INJURY (Month, Day, Year) 28. DATE OF INJURY At home, Ierm, street, factory, office 28. LOCATION (Street end Number or Rural Route Number, City or Town, State) 29. CERTIFIER (Check only one) 29. MEDICAL EXAMINER: On the best of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. 29. SIGNATURE AND TITLE OF CERTIFIER 29. LICENSE NUMBER 29. LICENSE NUMBER 29. LICENSE NUMBER 29. LICENSE NUMBER 29. DATE SIGNED (Month, Day, Year) 29. LICENSE NUMBER 29. LICENSE NUMBER 29. DATE SIGNED (Month, Day, Year) 29. LICENSE NUMBER 29. DATE SIGNED (Month, Day, Year) 29. LICENSE NUMBER 29. DATE SIGNED (Month, Day, Year) |
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| TO BE COMPLETED BY PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 ER/Outpatient 3 OOA 4 Mursing Home 5 Recidence 6 Other (Specify) 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 28e. DATE OF INJURY AT WORK? 2 Accident |
| BE COMPLETED BY PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 |



| 1 | | | STATE REGISTR | A |
|---|---|---|------------------|---|
| Г | 4 | _ | ECEDENT'S | N |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| REGISTRAR | | | | CERT | FIFIC | ATE O | F DEA | TH | | REG. NO | | | |
|---|----------------------------|--|---|--------------------|---------------------------|----------------|--------------------------|-----------|-----------------|-----------------------------------|------------|-------------------------|--|
| 1. DECEDENT'S NAME (First, | Middle, Last) | | | | | | | | | E OF OEATN | | | 3. TIME OF OEATH |
| EVAN LUTHER | R JONE | S JR. | | | | | | | ALICI | ist 27 | 199 | YEAR | м |
| 4. SOCIAL SECURITY NUMBER | ER | 5. SEX t M 2 F | | In yrs. last birth | | UNDER t YEA | | R 24 HRS. | 7. DATE (Mon | E OF BIRTN ith, Day, Year) | | 7 | NPLACE (State or Foreign try) |
| 220–28–3732 | | Λ. | 61 | V | - | | | | | <u>16–1933</u> | | Mar | yland |
| 90. FACILITY NAME (# nor ins | | | | | | Casca | N OR LOCATI | ION OF D | EATN | | | shine | |
| RESIDENCE OF DEC | EDENT 10b. COUNTY | | | | | | | | | | mar | JILIIC | |
| | Washi | | | | Casc | ww.or.co | CATION | | | | | | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| toe. STREET AND NUMBER | | | | | Cabe | I | 10f. ZIP COD | E | | | 10g. Cl | TIZEN OF | WHAT COUNTRY? |
| 14622 Mary] | land A | | | | | | 217 | - | | | | U.S | |
| 1 Never Married 2 1 Divor | | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE W | YES | 2 NO | | Il yea, | ecendent of apocify Cubi | in, Maxle | en, Puerto | IN? (Specify Yes Rican, etc.) | n or No- | 14. RAC Blec Spec | |
| 15. DECE | DENT'S FOU | CATION | | 18a. DECEDE | NT'S USU | l | | | | b. KIND OF BU | SIMESS/IN | OUSTRY | White |
| (Specify only Elementary/Secondary (0- | highest grade | Completed) College (1-4 or 5 - | +) | (Give kir | nd of work IOT use rel | done durina | most of worki | ng | " | | | | |
| 12 years | | | | Sale | sman | | | | | Chemic | al C | ompa | ny |
| 17. FATNER'S NAME (First, Mic | | - C | | | | | | | | Middle, Maiden | | | |
| Evan Luther | | s Sr. | | | | | | 4 | | Leite | | | |
| Betty Irene | | | | | | | | | | nber, City or Tow cade, M | | | 21719 |
| 20a. METNOD OF DISPOSITIO | ON | | 20b | . PLACE AND C | ATE OF D | SPOSITION | | | DA | - | | | own, Slata |
| t Reurial 2 Cremation 4 Donation 5 Other | (Specify) | | Re | etery cremator | y or other p Ven | cemet | ery 8 | -30- | -1994 | Hao | erst | own, | Maryland |
| 21. SIGNATURE OF PUNERAL | SERVICE LIC | ENSEE | | | | 22. NAME | AND ADDRE | SS OF FA | CILITY | 1221 | | | Blvd. N. |
| 1 Jour | No A | 1 Fili | 011 | | | | glas eral | | _ | | stow | m M | aryland |
| 23. PART I Enter the did | eases or c | complications the | t caused | the deeth. | Do not e | enter the | node of dy | ing, aud | ch sa car | rdlac or respi | ratory a | rrest, | Approximata |
| iMMEDIATE CAUSE (Fine disease or condition reaulting in death) | - | List only one cou | | | 4 1 | net | asta | fic | to | live |) | | interval Batween Onset and Deeth |
| Sequentielly list condition if any, leading to immed cause. Enter UNDERLYIN CAUSE (Disease or injur that inklated events resulting in deeth) LAST | liate NG Y | DUE TO | (OR AS A | CONSEQUEN | CE OF): | m's | die | elas | R | | | | |
| PART II. Other eignificer | nt condition | e contributing to | deeth b | ut not result | ting in th | ne underly | Ing ceuse | given in | Part I. | 24s. WAS AN PERFOR | RMED? | 241 | o. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| | | | | | | | | | | | | | t 🗌 YES 2 🗍 NO |
| 25. WAS CASE REFERRED TO | MEDICAL T | | | | | | PLACE OF D | EATN 404 | hook | | | | |
| EXAMINER? | | HOSPITAL: | ED/A | | | HEA: | | - | | | | | |
| 27. MANNER OF DEATN | | 1 Inpatient 2 I | | | . TIME OF | - | oma 5 A | ealdenca | | er (Specify) SCRIBE NOW I | N ILIPY O | CHBED | |
| 1 Natural 5 P | Pending nvestigation | (Month, D | | 1 | INJURY | | WORK? | ND | 200. DE | SOURCE HOW I | NJUNT O | CONED | |
| 3 Suicide 8 C | Could not be letermined | 28e. PLACE O building, | F INJURY atc. (Spec | — Al home, fi | erm, stree | t, lactory, of | fica | | 281, LO | CATION (Street of or Town, State) | and Numbe | or Rural | Route Number, |
| 29a. CERTIFIER (Check only | FYING PNYSK | CIAN: To the best of | my know | ledge, death o | ccurred at | the time, d | sta and place | , and du | to the ca | use(s) and mar | nner as st | Ited. | |
| | | | | | | | | | | | | | e) and manner as stated. |
| 29b. SIGNATURE AND TITLE OF THE AND TITLE OF THE AND ADDRESS OF | Way | 2tral | OF DE | ATN (ITEM 27) | (Type, Prin | t) | 29c, LIC | 121 | MBER 44 | 4 | 29d. DA | TE SIGNED | (Month, Day, Year) |
| | | <u> </u> | 131111111111111111111111111111111111111 | | | | | | | | | | · |
| 31. DATE FILED (Month, Day, Y | bar) | 32. REGISTRA | R'S SIGN | ATURE | | | | | | | | | |

hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

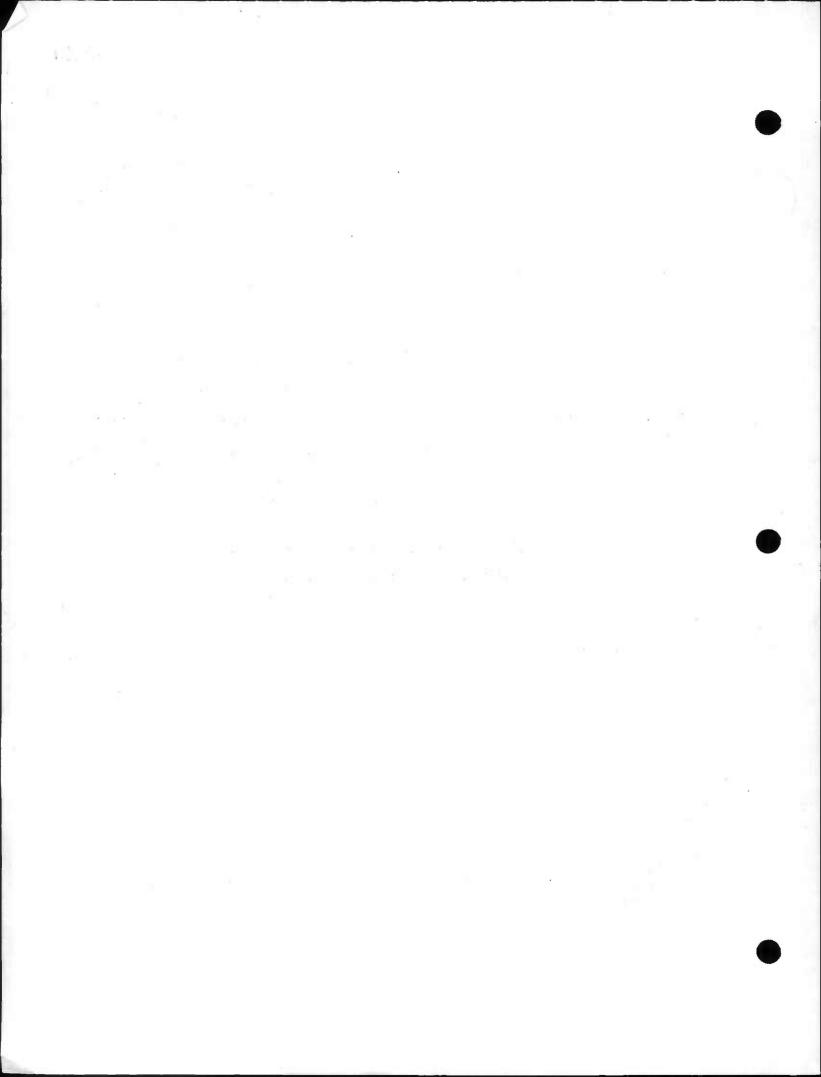
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit perma-be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notiffed at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



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| DIRECTOR | ANNE ARUND | | DICAL CEN | TER | | ANN | APOI | LIS | | | | AN | NE A | ARUNDEL |
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| _ | MARYLAND | ANNI | E ARUNDEL | | . I | ANNAP | OLIS | 3 | | | | | | 1 XXYES 2 N |
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| COMPL | 17. FATHER'S NAME (First, M | Marie dans | | | COOK | | | | | | | | | |
| | JAMES JONES | | | | | | | | | ME (First, Midd TH BEE | | umame) | | |
| BE | 19a. INFORMANT'S NAME (7 | Type/Print) | <u>-</u> | | 19b. MAILING | G ADDRESS | S (Street a | | | Route Number, (| | State. Zio C | ode) | |
| 임 | LEATHIA JON | ES | | | | | | | | Al AN | | | | 21403 |
| | 20a. METHOD OF DISPOSITI | | novel from State | | PLACE AND DATE | OFDISPOS | SITION (Na | | | DATE | , | ATION — CH | | |
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| cian. | -transit permit. Pages 1.2 | | |
| hospital or attending physi | ached for use as the buria | | 20 |
| : The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | | tem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| nours after death. Pag | filled in by the funeral di | on, or removal. | he medical examiner |
| cate be executed within | ohysician and completely | e prior to burial, cremati | er traumatic event, t |
| juires that the death certif | signed by the attending | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | ows any injury, or oth |
| G PHYSICIAN: The law req | er this certificate has been | th with the State Dept. of | larked, or Item 23 sh |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: | FUNERAL DIRECTOR: After | within 72 hours after deal | IMPORTANT: If Item 28 is marked, or lit |
| TO THE | TO THE | be filed | IMPOR |

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| · A | REGISTRAR | | | | CERTIF | ICATE | OF | DEATH | | REG. NO. | | | |
|--------------------------|---|-----------------------------------|--|------------------------------|--|-------------------|--|---|-----------------------------------|------------------------------|-------------|------------|--|
| 1. DEC | VIRGINIA | | HAZEL | | KII | FER | | | 2. DATE OF MONTH AUGUS | - 04 | 199 | YEAR | 3. TIME OF DEATH 00:17 a |
| | 36-28-201 | | 5. SEX | 6. AGE (in yrs. | last birthday) | IF UNDER | t YEAR DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF (Month, D August | DIEVELI | | | PLACE (State or Foreign |
| 9a. FA | CILITY NAME (If not I | institution, give s | treet and number) Memorial | | | | town akla | OR LOCATION OF DE | | | 9c. COUN | ty of D | EATH |
| RESI | DENCE OF DE | 1 | | | | | | | | | | | |
| | ryland | Garr | | | 10c. CIT | y, town o Swar | | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2XXNO |
| 1 | treet and number $1.1~{ m Box}~2$ | | | | | | 10 | 1. ZIP CODE 21561 | | | 10g. CITIZ | | HAT COUNTRY? |
| 3 ×× | RITAL STATUS Never Married 2 Widowed 4 Div | | 12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA | YES 2 | | 1 | yes, sp | CENDENT OF HISPAN Becify Cuben, Mexice 2 NO Specify | n, Puerto Rici | | or No— | Black | — American Indian, White, etc. |
| Ele- U 17. FAT | 15. DEI (Specify on mentary/Secondary (| CEDENT'S EDUC ly highest grade | CATION completed) College (1-4 or 5+) | - | DECEDENT'S (Give kind of ville. Do NOT us | work done d | CUPATION TO THE PROPERTY OF TH | ON ost of working | 16b. KI | ND OF BUS | INESS/INDI | | |
| U | nknown | V-12) | Comage (1-4 or 5+) | | Home | maker | • | | I | Iome | | | |
| 17. FAT | HER'S NAME (First, A | Aiddle, Last) | | | - | | | 18. MOTHER'S NA | ME (First, Mide | fle, Maiden | Sumame) | | . |
| J | lames Hen | ry Kif | er | | | | | Isabe | lle Kr | nox | | | |
| 198, // | FORMANT'S NAME (| ,, | | | | | | and Number or Rural I | | | | Code) | |
| W | Villiam D | . Kife | r | | Rt.1 | Box | 382 | , Auror | a, WV | 267 | 05 | | |
| XX B | ETHOD OF DISPOSIT uriel 2 Cremetion constion 5 Other | on 3 🗆 Rame | oval from State | cemetery | CE AND DATE | OF DISPOSI | TION (N | | DATE | 20c. LO | CATION — C | | |
| 21. 510 | NATURE OF FUNERA | AL SERVICE LIC | EHSEK & | 7.1 | | 22. 1 | NAME A | Boal Fun | CILITY | | | - Cara | |
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| cause CAUS that is | entleily list condit , isading to imme s. Entar UNDERLY SE (Diseasa or Inju nitisted events ting in death) LAS | diata ING ury | ¢ | | SEQUENCE OF | | 4 | 150u | 36 | | | | |
| 10001 | ang ar death, EAC | | d | | | | | | | | | | |
| PART | | nnt condition | s contributing to d | death but no | ot rasulting | in tha und | dariyin | g cause givan in | | a. WAS AND PERFOR | MED? | 24b. | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| | | | | | | | | | | | | | 1 YES 2 NO |
| EX | S CASE REFERRED 1 AMINER? YES 2 XO | O MEDICAL | HOSPITAL: | FR/Outgatient | 3 DOA | OTHER | 1: | LACE OF DEATH (Ch | | 200101 | | | |
| 1 🕏 | | Pending | 28e. DATE OF I | NJURY | 28b, TIM | | 28c. IN. | URY AT DRK? YES 2 NO | 28d. DESCR | | JURY OCC | URED | |
| 3 🗆 | Accident Suicide 8 | Could not be defarmined | 26s. PLACE OF building, s | INJURY — At tc. (Specify) | t home, tarm, s | street, facto | | | 281. LOCATIO | ON (Street a lown, State) | nd Number (| or Rural R | loute Number, |
| | | | CIAN: To the best of n | | | | | | | | | | and manner as stated. |
| 29b. Sk | GNATURE AND TITLE | - | | _ | M | e se | | 25c. LICENSE NUN | 31111 | | | 2-1-1-1-1 | (Month, Day, Hear) |
| 30. NAI | | | O COMPLETED CAUSI | | | | | 1 Ua | 37/1 | | - 17 | 23/0 | 14 |
| | Kobert | Gorals | ki M.D. | 311 N | . Four | th St | t. | Oakland, | Md. | 21550 | | | |
| AUG | 2 5 1994 | Your) iles | An HIPEGUSTAN | NATURI | E | | | | | | | | |
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| BALTIMORE, MARYLAND 21215-0020 | J.S | 7 |
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| O. BOX 68760, | certificate be executed with | A A A M. |
| P.O. BOX 68760, | ath certificate be executed with | A STATE OF THE STA |
| S, P.O. BOX 68760, | death certificate be executed with | A Second |
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| L RECORDS, P.O. BOX 68760, | law requires that the death certificate be executed with | |
| TAL RECORDS, P.O. BOX 68760 , | The law requires that the death certificate be executed with | |
| 11 AL RECORDS, P.O. BOX 68760, | N: The law requires that the death certificate be executed with | |
| VITAL RECORDS, P.O. BOX 68760, | CIAN: The law requires that the death certificate be executed with | |
| DF VITAL RECORDS, P.O. BOX 68760, | YSICIAN: The law requires that the death certificate be executed with | |
| J OF VITAL RECORDS, P.O. BOX 68760, | PHYSICIAN: The law requires that the death certificate be executed with | |
| ON OF VITAL RECORDS, P.O. BOX 68760, | ING PHYSICIAN: The law requires that the death certificate be executed with | |
| ION OF VITAL RECORDS, P.O. BOX 68760, | NDING PHYSICIAN: The law requires that the death certificate be executed with | |
| ISION OF VITAL RECORDS, P.O. BOX 68760, | TTENDING PHYSICIAN: The law requires that the death certificate be executed with | |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicia | Prince and the same of the sam |

CANADA PROPERTY

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician in TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burist-transplance he had within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

5

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1 - FOR STATE REGISTRAR | STATE OF MARYLAND / DEPART CERTIFIC | MENT OF HEALTH AND | MENTAL HYGIENE REG. NO. | |
|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATN | 3. TIME OF DEATN |
| Loui | se | Kellum | August 22 1 | 994 7:40PM M |
| 2 10/11001 | □ M 2 VF 70 YRS. M | IF UNDER 1 YEAR IF UNDER 24 HRS. ONTHS DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 09-20-23 | BIRTNPLACE (State or Foreign Country) |
| 36 1 7 22 1 7 | at Easton | Easton | | NTY OF DEATH |
| 100. STATE 10b. COUNTY | 10c. CITY, | TOWN OR LOCATION | | 10d. INSIDE CITY |
| MO. TO | 1607 (| ORDOVA | 10g. CIT | 1 V YES 2 NO |
| P.O. BOX | 241 | 2162 | 5 | 71.5 |
| 11. MARITAL STATUS 1 Never Merried 2 Merried | 2. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO | 13. WAS DECENDENT OF HISPAI If yes, specify Cuben, Mexico | NIC ORIGIN? (Specify Yee or No- | 14. RACE — American Indien, Black, White, etc. |
| 3 Widowed 4 Divorced | IF YES, GIVE WAR OR OATES | 1 TYES 2 TVNO Specific | y: | Specify Black |
| 15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12) | | rk done during most of working | 16b, KIND OF BUSINESS/IN | DUSTRY |
| Grade-7 | | se Wife | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | ME (First, Middle, Maiden Surneme) | ferr |
| 19a INFORMANT'S NAME (Type/Print) | W. Joshua | Le | aner | Williams |
| Charles E | Kellym P.O. | Box 241 - Col | Rdova Md | 21625 |
| 20e. METHOD OF DISPOSITION 1 Disposition | | r plecel 1 | SIZE COR | City or Town, State |
| 21. SIGNATURE OF FUNERAL SERVICE LICENS | SEE Newton | 22. NAME AND ADDRESS OF FA | CILITY | gova Md. |
| ▶ Janelle | C. Henry | HENRY FU | | Mbridge, Md. |
| 23. PART Enter the diseases, or com | nplications that caused the death. Do not | t enter the mode of dyling, suc | h ss csrdiac or respiratory ar | rest, Approximate |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) | M. Handa for MM. DUE TO (OR AS A CONSEQUENCE OF): | smel all | lung cance | Interval Between Onset and Death |
| Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A CONSEQUENCE OF): | | | |
| CAUSE (Disesse or Injury thet initisted eventa resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): | | | |
| PART II. Other significant conditions of | contributing to death but not resulting in | the underlying cause given in | Part I. 24a. WAS AN AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| odymperd no | ul desine | 2 to polycy | PERFORMED? | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| DID TORACCO LICE CONTINUE | | | | 1 TYES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL | BUTE TO CAUSE OF DEATH YES 28. PLACE OF DEATH | | N L L | |
| | IOSPITAL: | OTHER: | 8 Other (Specify) | |
| 27. MANNER OF DEATN 1 Americal 5 Pending | 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME (INJUR | OF 26c, INJURY AT | 28d. DESCRIBE NOW INJURY OC | CURED |
| 2 Accident Investigation 3 Suicide 6 Could not be 4 Nomicide determined | 26e. PLACE OF INJURY — At home, farm, stre- bullding, atc. (Specify) | | 281. LOCATION (Street end Number City or Town, State) | r or Rural Route Number, |
| The state of the s | N: To the best of my knowledge, desth occurred | | | |
| 2 MEDICAL EXAMINER: C | On the besis of examination and/or investigation, | | | |
| 29b. SIGNATURE AND TITLE OF CENTY IER | M.D. | 29c, LICENSE NUI | | e signed (Month, Day, Year) |
| 1 1 - | OMPLETED CAUSE OF DEATH (ITEM 27) (Typo, P) | ^ | sten unu 2 | 160/ |
| 31. DATE FILED (Month, Day, Year) | 32 REGISTRAR'S SIGNATURE | 110 IFFE. EU | TION , TO X | / |
| AUG 2 5 1994 | Julia d'avidson travdalle | | | |

August 1 7 II. T. Fried

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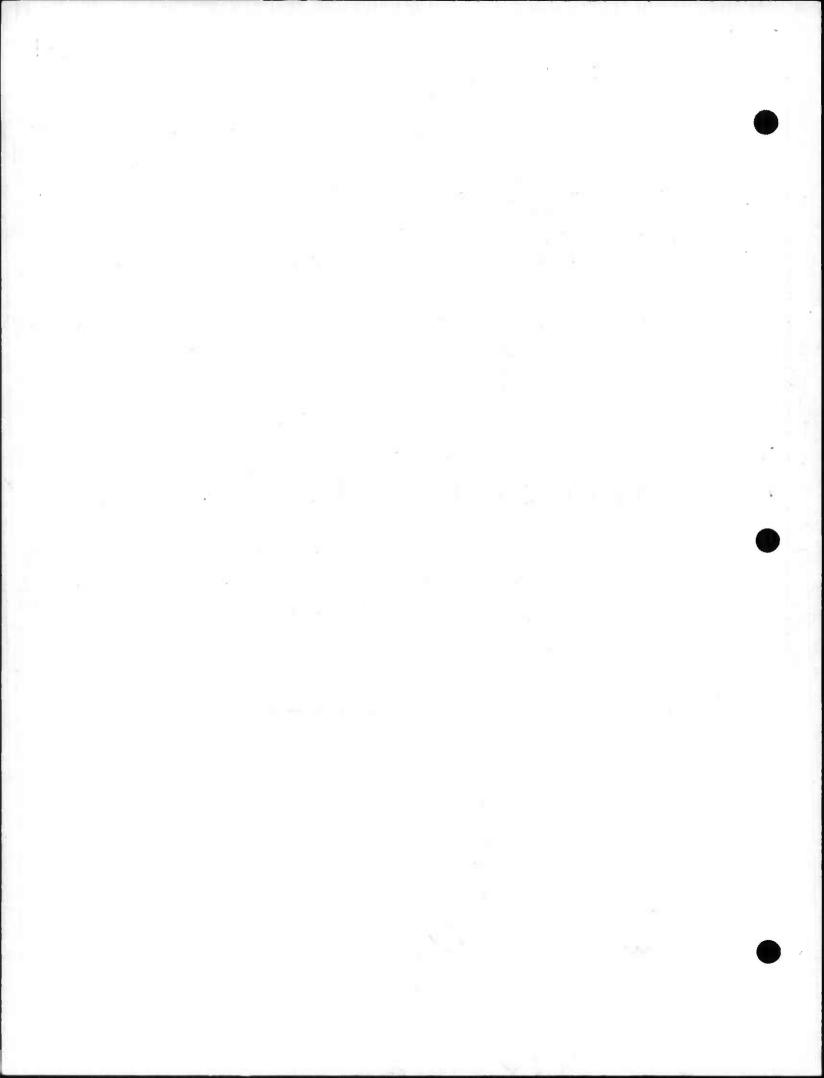
| KALWA TRANK JOSEFH - | BALTIMORE, MARYLAND 21215-0 | |
|----------------------|--|--|
| WAME KALWA | DIVISION OF VITAL RECORDS, P.O. BOX 68760, | AND ADMINISTRAL OF THE PARTY OF |

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

| | | 1. DECEDENT'S NAME (First, | Middle, Lest) | Frank | Jose | ph k | (alw | a | | | | 2. DATE OF MONTH | DEATH 8 | -27- | 94 YEAR | 3. TIME OF DEATH |
|---|---------------|--|-----------------------------------|--|------------------------|-------------------|-----------------|----------------------------|-------------|----------------------------|-------------|--------------------------------|------------------------------|-----------|------------|---|
| 1 | | 4. SOCIAL SECURITY NUME | BER | 5. SEX | | (In yrs. last i | | IF UNDER | 1 YEAR | IF UNDE | R 24 HRS. | 7. DATE OF | BIRTH | ./ | 7.7 | NPLACE (State or Foreign |
| | | 214-03-3198 | 8 | 1 X M 2 - F | | 79 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, E | Jay, Year) | 915 | Count | yland |
| should | | 9a. FACILITY NAME (If not in | stitution, give s | street and number) | | | | 9b. CITY, | TOWN | OR LOCAT | ION OF DE | | -, - | | NTY OF D | 2 |
| . S | СТОВ | Union Hosp | | f Cecil | Coun | ty | | E 11 | cton | 1 | | | | Cec | il | |
| 7) | EC | 10s. STATE | 10b. COUNT | Υ | | T | 10c. CIT | Y, TOWN O | R LOCA | TION | | | | _ | | 10d. INSIDE CITY |
| 4 | DIRE | Maryland | Ceci | 1 | | | E1 | kton | | | | | | | | LIMITS? |
| usit. | ERAL | 10e. STREET AND NUMBER 21-A Joseph | h Gall | aher Str | eet | | | | 10 | 2192 | | | | | S.A. | WHAT COUNTRY? |
| he burial-transit. | BY FUN | 11. MARITAL STATUS 1 Never Married 2 💢 3 Widowed 4 Divo | | 12. WAS DECEDED FORCES? IF YES, GIVE | 1 X YES | 2 NO | ED) | - 0 | yes, sp | | an, Maxica | IIC ORIGIN? (n, Pusrto Ric | | or No- | Blac | E — American Indian, k, White, alc. |
| e as t | ED | 15. DEC | EDENT'S EDU | CATION | _ | | | USUAL OC | | | | 16b, K | IND OF BUS | SINESS/IN | | |
| for us | | (Specify only Elementary/Secondary (0 | y highest grade 1-12) | College (1-4 or 5 | +) | (Give | kind of a | vork done d e retired.) | luring mo | ost of worki | ing | | | | | |
| ched ched | COMPLET | 8 | | | | Fir | cema | n | | | | Fi | re De | part | ment | |
| be detach | ш | 17. FATHER'S NAME (First, M Wal | ^{iddle, Last)} ter Ka | lwa | | | | | | 18. MOT | NER'S NA | ME (First, Mid Anna | dle, Maiden Kwia | | ski | |
| e 5 should notified | TO B | 19a. INFORMANT'S NAME (7 | | | | | | | | | | Stree | | | | D 21921 |
| ector, page | | 20a. METNOD OF DISPOSIT. 1 X Burial 2 Crematic 4 Donalion 5 Other | n 3 🗆 Ram | oval from State | | b. PLACE AN | | | | | Park | 8º29 1994 | | cation - | | yland |
| tuneral dir examiner | | 21. SIGNATURE OF FUNERA | L SERVICE LIC | CENSEE | | | | 22. | TICK | ND ADDRE | ss of f | OF Fu | neral | s, P | _ | |
| the fun oval. | | Don | سال | 8.6 | iel | 20 | | | 103 E1kt | West | : Sto MD | ckton 21921 | Stre -5521 | eet | | |
| and completely filled in by the funeral director, page 5 should be detached for use as the burial, cremation, or removal. An analog exempt, the medical examiner must be notified at once. | Z | iMMEDIATE CAUSE (Fir disease or condition resulting in death) | eert fallure. | a. BRCY | O (OR AS | A CONSECU | 1e L | em. | | la | A | | ati' | | | Approximate interval Betwee Onset and Dec |
| ending physician I Hygiene prior to or other traun | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. ## ZILLI MES & Disease of Disease or Injury that initiated events resulting in death) LAST b. ## ZILLI MES & Disease of Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | | many year | | | |
| ed by the att th and Menta any injury, | AL | PART II. Other significa | nt condition | ne contributing to | deeth l | but not re | suiting | in the un | derlyin | g ceuse | given In | Part i. 2 | te. WAS AN PERFOR | | 248 | WERE AUTOPSY FINDING |
| sign Heal | MEDICAL | | | | | | | | | | | _ ' | ☐ YES 2 | NO | | OF DEATH? 1 YES 2 NO |
| as been Dept. of 23 sho | ä | DID TOBACC | | CONTRIBUT | E TO | CAUS | E OF | DEA | rH , | YES [|] NC | | | | | |
| ficate has the State Dept State Dept ritem 23 | HYSICIAN: | 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO | O MEDICAL | HOSPITAL; | ☐ ER/Out | patient 3 | DOA | OTHER | 1: | | | 8 Other (| Specifys | - | | |
| DIRECTOR: After this certificate has been hours after death with the State Dept. of Item 23 sho | ВУ РНУ | | Pending Investigation | 28e. DATE Of (Month, I | F INJURY Day, Year) | | 28b. TIM INJ | _ | 28c. IN. | JURY AT ORK? YES 2 [| | 28d. DESC | | NJURY OC | CURED | |
| ECTOR: After s after death | ETED E | 3 Suicide 8 | Could not be determined | 28a. PLACE (building | OF INJUR | Y — At hom | e, łerm, : | street, facto | ory, offic | | | | ON (Street : Town, State) | | r or Rural | Route Number, |
| | COMPLE | | | ICIAN: To the best of | | | | | | | | | | | | s) and manner as stated. |
| TO THE FUNERAL be filed within 72 IMPORTANT: If | TO BE C | 296. SIGNATURE AND TITLE | while | al IKI | let- | r mi |) | | | | ENSE NUM | | 7 | | | 9/94 — |
| / | - | 30. AAME AND ADDRESS OF | ILAL | COMPLETED CAL | TEL | EATH (ITEM | 27) (Typo, | Print) 3 S ? | ng | est | 27 A | he, | ZIKI | ten | ,m | 9/94- |
| 4 | | 31. DATE FILED (Month, Day, SEP 07 | | 32. DEGISTR | AR'S SIGN | NATURE DE REAL | lett, | | -0 | | | | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



BALTIMORE, MARYLAND 21215-0020

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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2- hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, F | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene pnor to bunal, cremation, or removal. | IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
|---|--|--|--|
| HOSPITAL OR ATTE | FUNERAL DIRECTO | within 72 hours aft | TANT: If item 28 |
| TO THE | THI CL | be filed | IMPO |

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
|---|----------|
| CERTIFICATE OF DEATH | REG. NO. |

| | FOR STATE REGISTRAR | STATE OF MARYLAND |) / DEPART CERTIFI | MENT OF H | EALTH AND I | MENTAL HYGIENE REG. NO. | Ē | |
|------------------|--|--|-----------------------|---------------------|--|--|--------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | VEAD. | 3. TIME OF DEATH |
| | JOHN M. | LEMON | | | | August T | 9,1994 | 2:20 A _M |
| | A STATE OF THE PARTY OF THE PAR | | . last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH | 8. BIRT | THPLACE (State or Foreign |
| | 233-44-7435 9a. FACILITY NAME (If not institution, give stree | MXM 2 D F 63 | YRS. | | OR LOCATION OF DE | 5 ^M 7 ^M 2 5 ^M 7 ^M 3 ^M 1 | Wes | St Virginia |
| FUNERAL DIRECTOR | Memorial Hospit | _ | | Cumber | | | Alleg | |
| REC | 10a. STATE 10b. COUNTY | | | TOWN OR LOCAT | | | | 10d. INSIDE CITY LIMITS? |
| ō | Maryland Garret | it | | McHenry | | | | 1 TES XX NO |
| RAL | Lake Shore Dr. | Dog 29/1 | | | 21541 | | | WHAT COUNTRY? |
| NE | | 12. WAS DECEDENT EVER IN U.S. | 10450 | | | | | SA |
| BY FU | 1 Never Married 2XXMerried 3 Widowed 4 Divorced | FORCES? 1 Ves 2 IF YES, GIVE WAR OR DATES 21 Years | NO | II yes, spe | CENDENT OF HISPAN ecity Cuban, Maxicar 5 2/ NO Specify | NIC ORIGIN? (Specify Yes in, Puerto Ricen, atc.) y: | Bie | CE — American Indian, ck, White, alc. Icity: White |
| ED | 15. DECEDENT'S EDUCAT (Specify only highest grade co. | TION 18a | DECEDENT'S U | JSUAL OCCUPATIO | ON . | 16b. KIND OF BUSI | INESS/INDUSTRY | WILLCC |
| COMPLETED | Elamentary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use | retired.) | st of working | Cover | | |
| MP | 12 | | Arm | Ĭ | | | nment | |
| | 17. FATHER'S NAME (First, Middle, Last) ROSCOE Le | emon | | | | ME (First, Middle, Meiden S elma Mit | Sumame) | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | SHOII | 10h MAII ING | PROCES (Street) | | Route Number, City or Town, | | |
| 5 | Helena Lemon | | | | | enry, Md | 21541 | |
| | 20a. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Remove | | | F DISPOSITION (Nei | | | CATION — City or | |
| | 4 □ Donation 5 □ Other (Specify) | NGEE CUIT | berland | d Cremat | tory 8/1 | | berland | Md. |
| | · Wayse | Boal | | I | Boal Fune | eral Home St. Weste | rnnort | Md 21562 |
| | 23. PART I. Enter the diseases, or con | mplications that caused the | death. Do no | ot aniar the mo | da of dying, such | h ss cardiac or respir | etory arrest, | Approximate |
| | IMMEDIATE CAUSE (Finel disease or condition resulting in dath) | et only one cause on each i | | MON | 114,0 | DRY DIS | WIT | Interval Batween Onset and Death |
| z | | DUE TO (OR AS A CON | SEQUENCE OF | ESK | IRAZ | DRY DIS | STAE | 35 |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUS TO (OR AS A CON | SEQUENCE OF) | : | 71 | 7 - SX | MARC | ne |
| S | CAUSE (Disease or Injury | 0<511 | CATO | RP | 1414 | in-c/ | 78/7 | 0 |
| 出 | that initiated eventa resulting in death) LAST | DUE TOYOR AS A CON | SEQUENCE OF) | En, | 115 | U | 191/1 | conver |
| CEF | d | 1-511-1 | 1 | 11120 | 700 | | | |
| AL | PART II. Other significant conditions of | contributing to death but no | ot resulting in | tha underlying |) cause givan in | Part I. 24s. WAS AN A | | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| PHYSICIAN: MEDIC | TPOL | 1- | | | | 1 TYES 2 | | COMPLETION OF CAUSE DF DEATH? |
| ME | (11)- | | | | | _ | | 1 TES 2 NO |
| AN. | DID TOBACCO USE C | CONTRIBUTE TO CA | AUSE OF | | | | | |
| SIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER: | ACE OF DEATH (Che | | | |
| HYS | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 28b, TIME | | NO 5 Residence | 6 Other (Specify) 28d. DESCRIBE HOW IN | " " IDV OCCUBED | |
| | 1 Nettrel 5 Pending | (Month, Day, Year) | INJU | IRY WOI | YES 2 NO | 200. DEGOTION ITO. | JUNI OCCURED | |
| D BY | 2 Accident Investigation 3 Suicide 8 Could not be | 28s. PLACE OF INJURY — At building, atc. (Specify) | homa, term, st | | | 281. LOCATION (Street ar | nd Number or Rural | Route Number, |
| COMPLETED | 4 Homicide determined | bulleting, area toposity, | | | | City or Town, State) | | |
| 1 | 29a. CERTIFIER 1 DERTIFYING PHYSICIA | AN: To the best of my knowledge, | , death occurred | I at the time, deta | and place, and due | to the cause(s) and many | ner as stated. | |
| O. | one) 2 MEDICAL EXAMINER: | On the besis of examination and | or investigation | , in my opinion, de | eath occured at the | time, data and place, and | dua to the cause | (s) and manner as stated. |
| BEC | 240. SIGNATURE AND TITLE OF CERTIFIER | - // | | $\overline{}$ | 29c. LICENSE NUM | /BER | 29d. DATE SIGNE | Month, Day, Year) |
| 10 8 | 10011 | npan | 17 | 2 | D 1876 | 59 | 181 | 19/94 |
| ١ | James Raver M. | completed cause of death (| | | 'umberl: | and MD | 21502 | 1 |
| 100 | Danies Mayer II. | D. Memoria | . nosp | True - | , Ulling C = a v | allu, ri | 2 I J V 2 | |
| - 1 | AUG 2 2 1994 | 32 REGISTRAR'S SIGNATUR | E | | - | | | |

| TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 nours after death. Page 6 may be retained by the hospital or attending physician. |
|---|
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit in |
| be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal. |
| IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

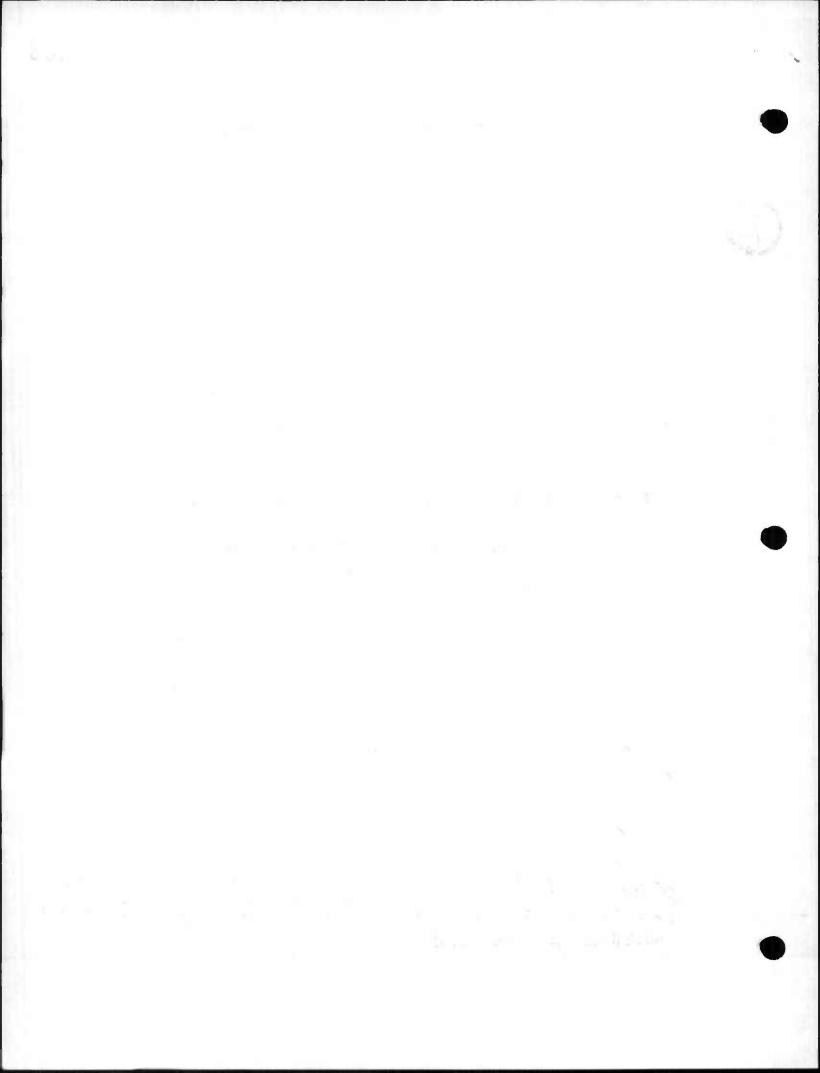
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. OECEOENT'S NAME (First, | | | | UEPAK ERTIFI | | | | MEN | TAL HYGIEN REG. NO. | E | | |
|--|--|---|--|--|---|---|--|---------------------------------------|---|----------------------|-------------------------|--|
| 1 7:11: | Middle, Last) | 1 05 | Fert | | | | | M | DATE OF OEATH | | YEAR | 3. TIME OF DEATH |
| 4. SOCIAL SECURITY NUMBE | ER 5.5 | 14- | AGE (In yrs. les | , | IF UNDER 1 | YEAR IF | UNDER 24 HRS. | 7. 0 | ATE OF BIRTH | | | LACE (State or Foreign |
| 219-01-20 | 27 | M 2 F | 74 | | MONTHS | DAYS HO | OURS MIN. | | Month, Day, Year) 2/18/19 | | Country) | /land |
| Sa. FACILITY NAME (If not ins | | and number) | , , | | 96. CITY, T | TOWN OR L | OCATION OF O | _ | 2/10/13 | 9c. COUNT | | |
| Carroll L | uthera | n Villa | σe | | West | min: | ster | | | Car | rol | |
| RESIDENCE OF DEC | EDENT 10b. COUNTY | | | | | | | | | Jul | | |
| J. C. W. S. S. W. C. | | | | 10e. CITY | , TOWN OR | | | | | | | IOd. INSIDE CITY LIMITS? |
| MD 10e, STREET AND NUMBER | Carro] | <u> </u> | | | west | - | ster | | | | | YES 2 NO |
| 29 Monroe | Chanal | L | | | | | | | | | | AT COUNTRY? |
| 11. MARITAL STATUS | | WAS DECEDENT E | /ED IN ILC AD | MEO | 40 40 | | 1157 | | RIGIN? (Specify Yes | 1 | | States |
| 1 Never Married 2 TV | Marriad | FORCES? 1 T | YES 2 N | | 10 1 | yes, specify | y Cuben, Mexica | ın, Pu | erto Rican, etc.) | or No- | Black, | – Americen Indian, White, etc. |
| 3 Widowed 4 Divor | ced | WWII | OH OATES | | ' | YES 2 | XNO Specif | y: | | | Specify | white |
| 15. DECE (Specify only | OENT'S EDUCATIO | ON niestech | 16a, DE | CEDENT'S L | JSUAL OCC | UPATION | faddin | | 16b. KINO OF BUS | SINESS/INDU | STRY | |
| Elementary/Secondary (0- | | ollege (1-4 or 5+) | lite. | Do NOT use | retired.) | ang most of | working | | | | | |
| | | | | bui1 | der | | | | constr | ucti | on/l | nomes |
| 17. FATHER'S NAME (First, Mic | | | | | | | | | irst, Middle, Meiden | Sumame) | | |
| John | | ffert | | | | | Lillie | | В. | Ward | | |
| 19a. INFORMANT'S NAME (Ty) | | | | | | | | | Number, City or Tow | | | |
| S. Dougla: | | 31.0 | | | | | | - | stminst | | _ | 21157 |
| 1 Buriel 2 Cremetion 4 Donation 5 Other | 3 Removal 1 | from State | | | | | 8/26 | | | CATION — CI | - 100 | |
| 21. SIGNATURE OF FUNERAL | | E | Kride | r's | Chur | Ch ! | Cemete | CIT | Wes | tmin | ste | MD |
| | | itto-Si | eiter | • | Pr | citt | s Fune | era | al Home | | | el ster, MD |
| 23. PART I. Entar the dis | seasea, or comp | olications that ca | Used the de | ath. Do no | ot entar th | na mode | of dying, auc | h aa | cardiac or respi | ratory arres | CM11 st. | Approximate |
| ahock, or he IMMEDIATE CAUSE (Fine | art failure. List | only one causa | on each line | | | | | | | | | Interval Between Onset and Death |
| disease or condition resulting in death) | * • a | CARC | NOA | 1A | 0 | F | PRO | 57 | AJE | | | Onset and Death |
| | = . | A I E A L | AS A CONSEC | C IA | · · | | | | | | | |
| Sequentielly list condition | | VEOF | 1-H. | SPI | | | n and | 6 | 1 | | | |
| If any, leading to immed cause. Enter UNDERLYIN | | DUE IU (UH | AS A CONSEC | DUENCE OF | Ur | = 1 | BOW | E | L- | | | |
| | NG | DUE TO (OH | AS A CONSEC | DUENCE OF | <i>O P</i> | = / | BOW | E | _ | | | |
| CAUSE (Disease or injurthat initiated events | NG | | AS A CONSEC | DUENCE OF |): | = / | BOW | E | _ | | | |
| CAUSE (Disease or injur | y | | AS A CONSEC | DUENCE OF |): | = 1 | BOW | E | _ | | | |
| CAUSE (Disease or injur that initiated events resulting in death) LAST | d | OUE TO (OR | AS A CONSEC | DUENCE OF |): | | | | | | | |
| CAUSE (Disease or injur that initiated events | d | OUE TO (OR | AS A CONSEC | DUENCE OF |): | | | | | | 1 | VERE AUTOPSY FINDINGS WAILABLE PRIOR TO |
| CAUSE (Disease or injur that initiated events resulting in death) LAST | d | OUE TO (OR | AS A CONSEC | DUENCE OF |): | | | | 1. 24a. WAS AN | MED? | 6 | |
| CAUSE (Disease or injur that initiated events resulting in death) LAST | d | OUE TO (OR | AS A CONSEC | DUENCE OF |): | | | | I. 24s. WAS AN PERFOR | MED? | 6 | MAILABLE PRIOR TO COMPLETION OF CAUSE |
| CAUSE (Disease or Injurthat Initiated events resulting in death) LAST PART II. Other algoritican | d | OUE TO (OR | AS A CONSEC | DUENCE OF |): | eriying ce | euse given in | Part | I. 24a. WAS AN PERFOR | MED? | 6 | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| CAUSE (Disease or Injurthat initiated events resulting in death) LAST PART II. Other aignificant of the control of the contro | d. d. MEOICAL HO | OUE TO (OR | AS A CONSEC | DUENCE OF | the unde | eriying ce | Buse given in | Part eck on | i. 24a. WAS AN PERFOR | MED? | 6 | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| CAUSE (Disease or Injurthat initiated events resulting in death) LAST PART II. Other aignificant 25. WAS CASE REFERRED TO EXAMINER? 1 \(\text{YES} \) 2 \(\text{N} \) NO | d. d. MEOICAL HO | OUE TO (OR | AS A CONSEC | DUENCE OF | other: | erlying ce 26. PLACE | Buse given in E OF OEATH (Ch | Part | 1. 24a, WAS AN PERFOR t YES 2 | MED? | 1 | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| CAUSE (Disease or Injurthat Initiated events resulting in death) LAST PART II. Other aignifican 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 P | d | OUE TO (OR | AS A CONSECTION OF THE PROPERTY OF THE PROPERT | DUENCE OF | OTHER: | 26. PLACE 26. PLACE 9 Home 5 8c. INJURY WORK? | E OF OEATH (Ch | Part | i. 24a. WAS AN PERFOR | MED? | 1 | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
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| DING PHYSICIAN: The law requires that the death certificate be executed with | After this certificate has been signed by the attending physician and completely filled in by the funeral director, p | death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| 9 | je. | at |
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31. DATE FILED (Month, Day, Year)

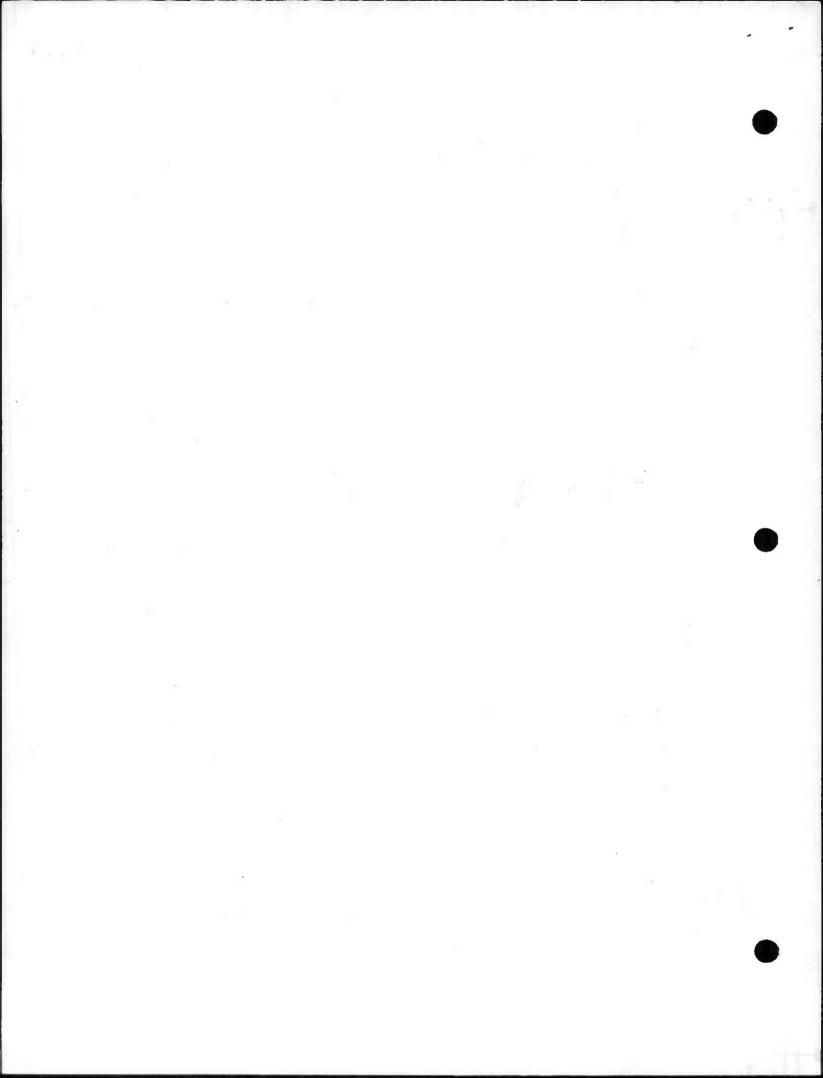
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28

32. BEGISTRAR'S SIGNATURE

| | | | | | | | | | | | 2-8 | 20234 |
|--|--|--|--|------------------------|---|--|--|---|--|--|---|--|
| | 1 - FOR STATE REGISTRAR | E OF MARYI | | PARTME TIFICA | | | | MENTAL | HYGIEN REG. NO. | | | |
| 100 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE O | DEATH | | | 3. TIME OF DEATH |
| | JASON DENNIS LASTER | | | | | | | JULY | 26, | 1994 | YEAR | 6:00 P. M |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | 6. AGE | (In yrs. last birt | holay) IF UN | IDER 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF | | | a, BIRTI | HPLACE (State or Foreign |
| | 217-21-6465 ¹⅓™ | 2 🗍 F | 15 | AS. MONTH | HS DAYS | HOURS | MIN. | (Month, I | 31, 1 | 979 | Count | ORIDA |
| 1 1 | 9a. FACILITY NAME (If not institution, give street and no | | 13 | 95.0 | YTY TOWN | OR LOCATION | ON OF DE | | JI, I | | INTY OF D | |
| DIRECTOR | CLEMENTS MD RT. 242 | | | - 1 | CLEM | | ON OF DE | | | | | MARY"S |
| E C | 10a. STATE 10b. COUNTY | | 10 | c. CITY, TOW | N OR LOC | ATION | | | | _ | | 10d. INSIDE CITY |
| 를 기를 기를 기를 기를 기를 기를 기를 기를 기를 기를 기를 기를 기를 | MARYLAND ST, MARY | 710 | | | | | ED | | | | | LIMITS? |
| | 100. STREET AND NUMBER | 1 3 | | PAI | | T RIV | _ | | | 10- 017 | TIZEN OF I | 1 TYES 2 NO |
| ₩. | | | | | - 1 | | | | | | | |
| FUNERAL | P.O. BOX 63 | | | | | 2067 | | | | | | STATES |
| 5 | 1 Never Married 2 Married FORG | DECEDENT EVER | 2 X X10 | ' ' | If yes, | specify Cuba | n, Maxicai | IIC ORIGIN? | Specify Yes en, etc.) | or No— | 14. RAC Blac | E — American Indian, k, Whita, atc. |
| B | 3 Widowed 4 Divorced | S, GIVE WAR OR C | DATES | | 1 🗌 Y | S 2 X NO | Specify | n e | | | Spec | * |
| 1 | 45 DECEDENTS EDUCATION | | T | <u> </u> | | | | | | | | ITE |
| 쁘 | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | (Give ki | ENT'S USUAL | one during r | FION most of workin | g | 16b. K | IND OF BUS | SINESS/IN | DUSTRY | |
| 쁘 | | (1-4 or 5 +) | 1 | NOT use retired | id.) | | | | | | | |
| ₽ I | 8 | | STU | DENT | | | | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | 16. MOTE | HER'S NA | ME (First, Mic | dle, Malden | Sumame) | | |
| l w l | ROY WAYNE LASTER | | | | | PA' | TRIC | IA MA | RLENE | CLA | RK | |
| B | 19a. INFORMANT'S NAME (Type/Print) | | 19b. M/ | AILING ADDRI | IESS (Stree | and Number | or Rural F | loute Number | City or Tow | n, State, Zi | p Code) | |
| 유 | ROY WAYNE LASTER | | P.C | BOX | 63. | PATII | XENT | RIVE | R. MA | RYI.A | ND 2 | 0670 |
| | 20a. METHOD OF DISPOSITION | 20 | b. PLACE AND | DATE OF DISP | POSITION / | | | OATE | 7 | CATION - | | |
| | 1 ☐ Burial 2 🂢 Cremation 3 ☐ Ramoval from 4 ☐ Donation 5 ☐ Other (Specify) | Stata Cer | METROP | ry or other place | ice) | | DV |] | | IRGIN | | , |
| | 21. S CHATLIFE OF FUNERAL SERVICE LIGENSES | | TETKOL | 2 | 22. NAME | AND ADORES | SS OF FAC | CILITY | | | VIA | |
| | u ne Blog | | | - 1 | Brin | sfiel | d Fu | neral | Home | 1 | | |
| | MICHAEL K. BLAN | | | | P.O. | Box | 279, | Leon | ardto | wn, | Mary | land 20650 |
| | 23. PART I. Enter the diseases, or complicate shock, or heert fellure. List only | ione that cause | d the death. | Do not en | ter the π | node of dyl | ng, such | as cardle | c or reapl | ratory ar | rest, | Approximete |
| 1 1 | | | | - | | | | | | ~ | | Interval Between Onset and Death |
| | disease or condition | 4.1.Ti | 11- | TRAL | 1 m | | T | . 4 | 1 | 1 | | |
| 1 1 | resulting in death) | | P | | | 1 4 | | 11 / 10 | | | | |
| 1 1 | | DUE TO (OR AS | A CONSEQUE | VCE OF): | | + A | FUI | UTTO | Llac | -01 | | |
| , | | DUE TO (OR AS | À CONSEQUE | NCE OF): | | + A | 101 | U TTO | Lac | -01 | | |
| NO | Sequentielly list conditions, b | DUE TO (OR AS | | | | + A | -01 | <i>U</i> /Te | (0 0 | -01 | | |
| ATION | | | | | | + A | | U Tre | Lac | -01 | | |
| FICATION | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | DUE TO (OR AS | A CONSEQUEN | NCE OF): | | + A | | U /Te | - Cae | 201 | | |
| RTIFICATION | Sequentielly list conditions, if any, leading to immadiate cause. Enter UNDERLYING | | A CONSEQUEN | NCE OF): | | + A | | U /Te | | -01 | | |
| CERTIFICATION | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | DUE TO (OR AS | A CONSEQUEN | NCE OF): | | + A | | <i>U</i> / Fe | | 201 | | |
| 핑 | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | DUE TO (OR AS | A CONSEQUEN | NCE OF): | | | | | la. WAS AN | AUTOPSY | |). WERE AUTOPSY FINDINGS |
| 핑 | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST | DUE TO (OR AS | A CONSEQUEN | NCE OF): | | | | Part I. 2 | Ia. WAS AN PERFOR | AUTOPSY RMED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| 뜅 | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST | DUE TO (OR AS | A CONSEQUEN | NCE OF): | | | | Part I. 2 | la. WAS AN | AUTOPSY | | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
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| MEDICAL CE | Sequentielly list conditions, if any, leading to immadiate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other algnificent conditions contrib DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | DUE TO (OR AS duting to deeth I | A CONSEQUENT Dut not reeul | OF DEA | ATH 26. | YES PLACE OF D | NO EATH (Che | Part I. 2 | 4a. WAS AN PERFOR | AUTOPSY IMED? NO | 241 | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| 핑 | Sequentielly list conditions, If any, leading to immadiate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other algnificent conditione contrib DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL FAMINER? 1 Y YES 2 NO 1 Inpa 27. MANNER OF DEATH 288. | DUE TO (OR AS duting to deeth I | A CONSEQUENT Dut not reeu | NCE OF): Iting in the | ATH 26. HER: Nursing He | TYES PLACE OF D | NO EATH (Che | Part I. 2 | 4a. WAS AN PERFOR | AUTOPSY IMED? NO | 241 | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| PHYSICIAN: MEDICAL CE | Sequentielly list conditions, if any, leading to immadiate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other algnificent conditions contrib DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | DUE TO (OR AS DU | A CONSEQUENT Dut not reeu | OF DEA | ATH 26. IER: Nursing Hc | YES PLACE OF D | NO EATH (Che | Part I. 2 | 4a. WAS AN PERFOR | AUTOPSY IMED? NO | 241 | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL CE | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other algnificent conditions contributed in the conditions of the contributed in the conditions of | DUE TO (OR AS DUE TO (OR AS uting to deeth I IBUTE TO TAL: tlant 2 □ ER/Out OATE OF INJURY (Month, Day, Year) | A CONSEQUENT Dut not reeule CAUSE | OF DEA | ATH 26. II 28c. II 1 | YES PLACE OF DOMES TO REVIOUS AT YORKY | NO EATH (Che | Part I. 2 1 1 Other (i. 28d. OESCI | 4a. WAS AN PERFOR | AUTOPSY MED? NO NO NO NO NO NO NO NO NO NO NO NO NO | 24t | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| ED BY PHYSICIAN: MEDICAL CE | Sequentielly list conditions, If any, leading to immadiate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other algnificent conditions contrib DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL BAMINER? 1 YES 2 NO 1 Inper 27. MANNER OF DEATH 28a. 1 Natural 5 Pending investigation 28a. | DUE TO (OR AS DU | A CONSEQUENT Dut not reeule CAUSE | OF DEA | ATH 26. II 28c. II 1 | YES PLACE OF DOMES TO REVIOUS AT YORKY | NO EATH (Che | Part I. 2 1 1 Other (i. 28d. OESCI | Aa. WAS AN PERFOR YES 2 | AUTOPSY MED? NO NO NO NO NO NO NO NO NO NO NO NO NO | 24t | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 XNO |
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| ED BY PHYSICIAN: MEDICAL CE | Sequentielly list conditions, If any, leading to immadiate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other algnificent conditione contrib DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL FAMINER? 1 YES 2 NO HOSPI 1 Inpa 27. MANNER OF OEATH 28. WAS CASE REFERRED TO MEDICAL FAMINER? 1 YES 2 NO 1 Inpa 27. MANNER OF OEATH 28. WAS CASE REFERRED TO MEDICAL FOR MANNER OF OEATH 29. CASCIDENT STREET OF MEDICAL FOR MANNER OF OEATH 29. CERTIFIER Check only 1 CERTIFYING PHYSICIAN: TO III | DUE TO (OR AS DU | CAUSE Lipstlant 3 28 Y — At home, wiedge, death of | OF DEA | ATH 26. HER: Nursing He 25c. II 1 [factory, off | YES PLACE OF D PLACE O | NO EATH (Che laidenca | Part I. 2 Dock only one) Other (c 28d. OESCI City or | As. WAS AN PERFORM PERFORM YES 2 Specify) ON (Street a fown, State) | AUTOPSY MED? NO NO NO NO NO NO NO NO NO NO NO NO NO | 24th CURED or or Rural | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 XNO Y RT 2 Y Z Route Number, |
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| E COMPLETED BY PHYSICIAN: MEDICAL CE | Sequentielly list conditions, If any, leading to immadiate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other algnificent conditione contrib DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL FAMINER? 1 YES 2 NO HOSPI 1 Inpa 27. MANNER OF OEATH 28. WAS CASE REFERRED TO MEDICAL FAMINER? 1 YES 2 NO 1 Inpa 27. MANNER OF OEATH 28. WAS CASE REFERRED TO MEDICAL FOR MANNER OF OEATH 29. CASCIDENT STREET OF MEDICAL FOR MANNER OF OEATH 29. CERTIFIER Check only 1 CERTIFYING PHYSICIAN: TO III | DUE TO (OR AS DU | CAUSE Lipstlant 3 28 Y — At home, wiedge, death of | OF DEA | ATH 26. HER: Nursing He 25c. II 1 [factory, off | YES PLACE OF D PLACE OF D THE S Revision And The S THE | NO EATH (Che laidenca | Part I. 2 1 1 1 1 1 1 1 1 1 1 1 1 1 | As. WAS AN PERFORM PERFORM YES 2 Specify) ON (Street a fown, State) | AUTOPSY IMED? NO NO AND | 24t CUP CURED or or Rural the cause(| AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 XNO Y RT 2 Y Z Route Number, |
| BE COMPLETED BY PHYSICIAN: MEDICAL CE | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL FAMINER? 1 | DUE TO (OR AS DU | CAUSE Lipstlant 3 28 Y — At home, wiedge, death of | OF DEA | ATH 26. HER: Nursing He 25c. II 1 [factory, off | YES PLACE OF D PLACE OF D THE S Revision And The S THE | NO EATH (Che aldenca | Part I. 2 1 1 1 1 1 1 1 1 1 1 1 1 1 | As. WAS AN PERFORM PERFORM YES 2 Specify) ON (Street a fown, State) | AUTOPSY IMED? NO NO AND | 24t CUP CURED or or Rural the cause(| AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO ROUTE Number, 8) and manner as stated. |
| E COMPLETED BY PHYSICIAN: MEDICAL CE | Sequentielly list conditions, if any, leading to immadiate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other algnificent conditione contrib DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpe 27. MANNER OF OEATH 28a. 27. MANNER OF OEATH 28a. 28a. 29a. CERTIFIER OF CERTIFYING PHYSICIAN: TO III (Check only one) 2 MEDICAL EXAMINER: On Iha 29b. SIGNATURE AND TITLE OF CERTIFIER | DUE TO (OR AS DU | A CONSEQUENT A CON | OF DEA | ATH 26. HER: Nursing He 25c. II 1 [factory, off | YES PLACE OF D PLACE OF D THE S Revision And The S THE | NO EATH (Che aldenca | Part I. 2 1 1 1 1 1 1 1 1 1 1 1 1 1 | As. WAS AN PERFORM PERFORM YES 2 Specify) ON (Street a fown, State) | AUTOPSY IMED? NO NO AND | 24t CUP CURED or or Rural the cause(| AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO ROUTE Number, 8) and manner as stated. |

DHMH-16 Rev 1/89



TO BE COMPLETED BY FUNERAL DIRECTOR

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCIENE

| 1 - STATE REGISTRAR | | 0.7.1.2 0.1 | | CERTIF | ICATE | OF | DEAT | ГН | | REG. NO | | | | |
|---|--------------------------|---------------------------|------------------------|---------------------------------|-----------------------------|------------|--------------------------|-----------|-------------------------|-------------|------------|-----------------|----------------------------------|------------------------------|
| 1. DECEDENT'S NAME (First, | Middle, Last) | | | | | | | | 2. DATE OF MONTH | DEATH | AY | YEAR | 3. TIME OF | F DEATH |
| MIRIAM S. | LEWIS | | | | | | | | August | | | 1994 | 1:25 | P ** |
| 4. SOCIAL SECURITY NUMBER | BER | 5. SEX | 6. AGE (In yr | s. last birthday) | IF UNDER | | IF UNDER | | 7. DATE OF (Month, D | | | 8. BIRT Coun | HPLACE (State | te or Foreign |
| 138-01-7828 | | 1 □ M 2 X F | 72 | YRS. | MONTHS | DAYS | HOURS | MIN. | Sept. | | 921 | | N | |
| 9s. FACILITY NAME (If not in | stitution, give s | street and number) | | | 96. CITY | , TOWN | OR LOCATI | ON OF D | EATH | | 9c. C0 | DUNTY OF | DEATH | |
| 25467 Milita | ary Roa | d | | | Ca | escad | e | | | | Was | hingt | on | |
| 10e. STATE | 10b. COUNT | Υ | | 10c. CIT | ry, town c | OR LOCAT | TION | | | | | | 10d. INSID | E CITY |
| MD | W | ashington | | | Cas | cade | : | | | | | | 1 TYES | |
| 100. STREET AND NUMBER 25467 Milita | mar Door | d | | - | | 101 | r. ZIP COD | € 719 | | | 10g. C | USA | WHAT COUN | TRY? |
| 11. MARITAL STATUS | aly rock | 12. WAS DECEDEN | IT EVER IN U. | S. ARMED | 13. | WAS DEC | | | NIC ORIGIN? (| Specify Ye | s or No- | 14. BAC | E — America | n Indian. |
| 1 Never Married 2 3 Wildowed 4 Divo | | FORCES? 1 | YES 2 | S NO | | ll yes, sp | | ın, Mexic | an, Puerto Rice | | | Spe | ck, Whits, ato city: White | |
| 15, DEC | EDENT'S EDU | ICATION | 16 | a. DECEDENT'S | USUAL O | CCUPATE | ON | | 16b. KI | ND OF BU | ISINESS/ | INDUSTRY | TELLOC | |
| (Specify online Elementary/Secondary (I | y highest grade 0-12) | College (1-4 or 5 | •) | (Give kind of life, Do NOT u | work done (se retired.) | during ma | ast of working | ng | | | | | | |
| 8th | | | | łomemake: | r | | | | | O | wn h | ome | | |
| 17. FATHER'S NAME (First, M | liddle, Last) | | | | _ | | 18. MOT | HER'S N | AME (First, Mick | de, Maider | Sumame | e) | | |
| Harry Lacke | | | | | | | | | e (Dubb | | | | | |
| 19a. INFORMANT'S NAME (| | | | | | | | | Route Number, | City or Tov | vn, Stata, | Zip Code) | | |
| Jean G. Leg | | | | | | | | e, M | 21719 | I | | | | |
| 1 Buriel 2 Cremetic | on 3 🗆 Rem | noval from State | | Bethel 0 | | | | | 8/29 | Cas | | — City or 1 | lown, State | |
| 21. SIGNATURE OF FUNERA | | CENSEE | | | | | | SS OF F | FUNERAL | | | | | |
| Comes | 17. E | Successors | A/2 | | | | | | reet, W | | | | 7268 | |
| 23. PART Enter the d | liseases, or | complications the | t caused th | e death. Do | | | | | | _ | | | | roximata |
| ahock, or h | | List only one car | use on each | ilna. | | | | | | | | | | rval Between et and Death |
| disease or condition | - | m | etasto | to Li | me (| CAL | cer | | | | | | 1 | Phrones |
| resulting in daeth) | , | | | ONSEQUENCE C | | | | | | | | | | |
| Commentally, that conditi | | b | | | | | | | | | | | | |
| Sequentielly list condit if any, leading to imme | diata | DUE TO | (OR AS A CC | ONSEQUENCE O | OF): | | | | | | | | | |
| cause. Enter UNDERLY CAUSE (Disease or Inju | | C | (OB 48 4 00 | ONSEQUENCE O | ND. | | | | | | | | | |
| that initiated events resulting in deeth) LAS | т | DOE 10 | (OR AS A CC | ONSEGUENCE C | <i>)</i>): | | | | | | | | İ | |
| | | d | | | | | | | | | | | - | |
| PART II. Other eignifica | ent condition | ns contributing to | desth but | not resulting | In the ur | nderlyin | g cause | given ir | Part I. 2 | Ia. WAS A | N AUTOP | SY 24 | Ib. WERE AUT | OPSY FINDINGS |
| | | | | | | | | | 1 | ☐ YES | | , | | ON OF CAUSE |
| | | | | | | | | | | | | | 1 DATES | |
| | | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED 1 EXAMINER? | TO MEDICAL | HOSPITAL: | | | Leeve | | LACE OF I | DEATH (C | heck only one) | | | | | |
| 1 TES 2 XNO | | 1 Inpatient 2 | ☐ ER/Outpatk | ent 3 🗆 DOA | 4 Nu | | ne 5 💢 R | Issidence | 8 Other (| Specify) | | | | |
| 27. MANNER OF DEATH 1 Netural 6 | Pending | 28s. DATE Of (Month, i | F INJURY Day, Year) | 28b. Til | ME OF IJURY M | W | JURY AT ORK? YES 2 | □ NO | 28d. DESCI | RIBE HOW | INJURY | OCCURED | | |
| 2 Accident 3 Suicide | Investigation | 28e. PLACE | OF INJURY — | At home, farm, | street, fac | | | | | | | nber or Rura | l Route Numb | 9¢, |
| 4 Homicide | Could not be determined | building | , stc. (Specify) | | | | | | City or | Town, State | 9) | | | |
| (Orleck orly > | | SICIAN: To the best of | | | | | | | | | | | e(s) and manr | ner ss stated. |
| 296. SIGNATURE AND TITLE | | | | | | | | ENSE NU | | | | | ED (Month, Da | |
| Jessel 4 | 1. St | a + | Bepou | | | | | | 062 | | | 4 | | 1994 |
| 30. HAME AND ADDRESS O | F PERSON W | HO COMPLETED CAL | JSE OF DEATH | | | | | | | | | | | |
| JOSEOP ! | 7. 31 | remort. | 111 6 | D. 105 | SIE | m. | 0,0 | 51. | two | 000 | 151 | 11 | Kallel | |
| 31. DATE FILED (Month, Day, | | GISTR | AR'S SIONATI | Parkel | and . | | | | | | | | | |
| AUG 2 | अ ।अअ 4 | 0 | | , | | | | | | | _ | | | |

IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within from the function of the function page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dapt. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | | REGISTRAR | | | CHIL | ICATE (| JF DEA | 111 | RE | G. NO. | | |
|---------------|------------|--|---------------------------|--|---------------|---------------------------------|-------------------|-------------|--------------------|---|-------------------|---|
| ŀ | ł | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF DE | | | 3. TIME OF DEATH |
| 1 | | WILLIAM | CURTIS | ! | MACI | ANTE | | | 08 | 21 | 94 | 5.00 PM |
| | | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. In | | IF UNDER 1 YE | SR AR IF UNDER | 24 1/20 | 7. DATE OF BI | | | 5:00 P M NPLACE (State or Foreign |
| | | 4. OUGAL GEOGRAFI HOMBER | | o. AGE (III y/s. III | | MONTHS DA | | MIN. | (Month, Day, | | 8. BIRT | NPLACE (State or Foreign try) |
| | į | <u>578-30-7285</u> | 1 Q M 2 □ F | 66 | YRS. | | | | 03 1 | 3 28 | Peni | nsylvania |
| | | Se. FACILITY NAME (If not institution, give | street end number) | | | 9b. CITY, TO | VN OR LOCATI | ON OF DE | EATN | | OUNTY OF I | DEATH |
| 9 | ב | CACDED HEADT | HOCDITAL | | | OTD CT | TITLE ANT | | | | | |
| activation | - 1 | SACRED HEART | HOSPITAL | | | CUMI | BERLANI |) | | | ALLEGA | ANY |
| 1 6 | 3 | 10e. STATE 10b. COUNT | Υ | | t0c, CIT | Y, TOWN OR LO | CATION | | - | | | 10d. INSIDE CITY |
| 1 9 | <u> </u> | 260 000 3 | | | 100 | | | | | | | LIMITS? |
| | - 1 | Maryland Garr | ett | | Fr | iendsv | rrre | | | | | t YES 2 NO |
| < | ₹ 8 | 10e. STREET AND NUMBER | | | | | 10f. ZIP COD | E | | 10g. | CITIZEN OF | WHAT COUNTRY? |
| CHAICDAL | 5 | Star Route, Box 10 | M_B | | | | 2 | 1531 | | | US | λ |
| 13 | | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN ILS AL | DMED | 42 1400 | | | | | | |
| ü | 2 | 1 Never Merried 2 Nerried | | YES 2 | | If yes | , specify Cube | m, Maxica | NIC ORIGIN? (Spe | etc.) | - 14. RAC Blac | E — American Indian, k, White, etc. |
| 2 | - 1 | 3 Widowed 4 Divorced | IF YES, GIVE W | AR OR DATES | | 1 🗆 | YES 3 NO | Specifi | y. | | Spec | |
| | | | l WW | 2 | | 1 | | | | | l wh | nite |
| ļ. | ű | t5. DECEDENT'S EDL (Specify only highest grad | | 16a. Di | ECEDENT'S | USUAL OCCU | PATION | | 16b. KIND | OF BUSINESS | INDUSTRY | |
| 5 | . II | Elementary/Secondary (0-12) | College (1-4 or 5 | iii | e. Do NOT us | vork done during e retired.) | | | | | | |
| ā | | 12 th | | | lice. | Office Nator | / | - | Wash | ington | DC G | overnment/ r's Office |
| COMPI ET | ١ ا | 17. FATHER'S NAME (First, Middle, Last) | | | COLL | acut. | | | ME (First, Middle, | | | s office |
| | | The second second second | _ | | | | | | | | = / | |
| u | | Joseph Allan Mac | Lane | | | | | | . Stead | | | |
| 9 | | 19a. INFORMANT'S NAME (Type/Print) | | 19 | 96. MAILING | ADDRESS (Str | eet and Numbe | r or Rural | Route Number, Cit | y or Town, State, | Zip Code) | |
| i F | - | Nancy MacLane | | 5 | Star 1 | Route, | Box 1 | 04-B | , Frien | dsville | e, MD | 21531 |
| | | 20e. METHOD OF DISPOSITION | | | | OF DISPOSITION | | | 1 | 20c. LOCATION | | |
| | | 1 Burial 2 Cremetion 3 Ren 4 Donation 5 Other (Specify) | noval from Stata | cemetery, cri | rematory or o | ther place) | | | 1 | | | |
| | - IE | 21. SIGNATURE OF FUNERAL SERVICE LI | CENTER | <u>Countr</u> | y Sic | de Crer | natory | 8- | 22-94 | Davids | <u>ville</u> | PA. |
| | ı | 21. SIGNATURE OF PUNEBAL SERVICE L | CENSEE | | | | E AND ADDRE | | | | | |
| | | Dalla Tean | DLPLV. | main | 7 | | | | 1. Homes | | | MD 21526 |
| | - | 23. PART I. Enter the diseases, or | | | | 155 | Main | Stro | et. P.O | Box 2 | 75 · C | MD 21536 |
| | | ahock, or heart failure. | Complications the | t caused the d | eath. Do r | not anter the | mode of dy | ing, auc | h aa cardiac o | r reaplratory | arrest, | |
| | | IMMEDIATE CAUSE (Final | 4 | / | | 1 | | | | | | Interval Between Onset and Death |
| | 1 | disease or condition | 1110+ | 20-64 | - 1 | roct | 2.40 | | arcino | | | |
| | H | resulting in death) | a. FVI () | (OR AS A CONSE | | | 416 | | u cone | srng | | |
| | | | DOE 10 | (ON AS A CONSE | OUENCE O | r): | | | | | | |
| CERTIFICATION | { | Sequentially list conditions, | b | | | | | | | | | |
| ı | | if any, laading to immediate | DUE TO | (OR AS A CONSE | OUENCE O | F): | | | | | | |
| 2 | | CAUSE (Disease or injury | C | | | | | | | | | |
| <u> </u> | | thet initiated events | DUE TO | (OR AS A CONSE | OUENCE O | F): | | | | | | |
| 6 | ē | resulting in death) LAST | 4 | | | | | | | | | |
| 1 6 | 5 | | | | | | | | | | | |
| | | PART II. Other aignificant condition | ns contributing to | death but not | rasulting | in the under | ying cause | given in | | WAS AN AUTOP | SY 246 | . WERE AUTOPSY FINDINGS |
| FOICAL | | (hurante Obs | Huckens | Pulu | yona | m 7 | 15 eas | 0 | | PERFORMED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| C | 3 | | | | Juna | 10 | 1 5 697 | | — ¹ [□] | YES 2 NO | | OF DEATH? |
| 2 | | | | | | / | | | | | | 1 YES 2 NO |
| | | DID TOBACCO USE | CONTRIBUTE | TO CAU | SE OF | DEATH | YES [|] NC | | | | |
| PHYSICIAN. | Ę | 25. WAS CASE REFERRED TO MEDICAL | | | | 2 | B. PLACE OF D | EATN (Ch | eck only one) | | | |
| 1 2 | ś II | EXAMINER? | HOSPITAL: | ER/Outpetlant | 3 DOA | OTHER: | Home & Da | andda a a c | e | off el | | |
| . Ž | | 27. MANNER OF DEATH | | | - | | | andeuce | 8 Other (Spec | | 0.000 | |
| ä | | 1 Netural 5 Pending | 28e. DATE OF (Month, D | ay, Year) | 28b. TIM | URY | INJURY AT WORK? | 97 | 28d. DESCRIBE | NOW INJURY | OCCURED | |
| 2 | : 1 | 2 Accident Investigation | | | | M 1 | YES 2 | NO | | | | |
| | | 3 Suicide 8 Could not be | 28a. PLACE O | F INJURY — At he atc. (Specify) | ome, farm, | street, factory, | offica | | 281. LOCATION | (Street and Nun | ber or Rural | Route Number, |
| I E | | 4 Homicide determined | building, | ero: (Opotiny) | | | | | City or Town | n, Stere) | | |
| COMPI ETEN | : 1 | 29e. CERTIFIER | | | | - Tyver - De- | | 1,00 | | | | |
| 9 | | (Check only | | | | | | | | | | |
| 6 | 5 | 2 MEDICAL EXAMIN | ER: On the basis of a | xamination and/or | Investigation | n, In my opinio | m, death occu | rsd at the | time, date and p | lace, end dua t | o the ceuse(| s) end manner es atated. |
| | | 280, SIGNAPONE AND TITLE OF CENTIFIE | B / | 7 | | | 29c LIC | ENISE NUR | WBER | 204 1 | DATE SIGNE | O (Month, Day, Year) |
| n n | 5 | 15/0/ | .// | | | | M | 1 3 | C/21 | | 0/- | >> 6 |
| 2 | 2 | NO MANU AND ADDRESS OF BERNA | Marin Committee | e or promi | | Marine . | 11/1 | 10 | 2177 | | 0/6 | 6/4/ |
| 1 | | 30. NAME AND ADDRESS OF PERSON NO | CONSECTED CAU | SE OF DEATH (ITE | # 27) (Type, | | - 0/ | | B | 1 | / | / |
| | | Morras Evan | (Masse | 11/1 | 1) | 9125 | fron | Di | r. (1 | imbe | vlan | dan |
| | | 31. DATE FILED (Month, Day Year) | 4 32 MEGISTIN | A'S SIGNATURE | al de | | | - / | | W 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | |
| | | AUG Z 4 199 | 4 10000 | The Control of the Co | | | | | | | | |
| 1 | 100 | | / | | | | | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTME CERTIFICA | | | MENTAL HYGIEN | _ | 20201 |
|---------------|--|--|---|----------------------|--|---|------------------|---|
| 1000 | 1. DECEDENT'S NAME (First, Middle, Last) FRANCIS | EDWARD | McKENZ | | | 2. OATE OF DEATH | | 3. TIME OF DEATH 7:54 |
| | 4. SOCIAL SECURITY NUMBER 220 –40 – 1590 | 7€ M 2 □ F 53 | YRS. MONT | | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) May; 22, 19 | C | MRTHPLACE (State or Foreign country) Md |
| TOR | 9a. FACILITY NAME (If not institution, give sin 12 BRANDY WINE RESIDENCE OF DECEDENT | | | JMBER | LAND | EATH | 9c. COUNTY C | EGANY |
| DIRECTOR | | legany | 10c. CITY, TOW | n on Local Imberl | | · · · · · · · · · · · · · · · · · · · | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| FUNERAL | 12 Brandywine | | | | ZIP CODE 21502 | | U. | OF WHAT COUNTRY? |
| B | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 W NO | II yea, sp | ENDENT OF HISPAI ecity Cuban, Maxica 2 NO Specif | NIC ORIGIN? (Specify Yea in, Puarto Rican, atc.) y: | | RACE — American Indian, Black, White, etc. Specify: White |
| LETED | 15. DECEDENT'S EDUC (Specify only highest grade of the contant of | | 16a. DECEDENT'S USUAL (Give kind of work do life. Do NOT use retire | ne durina mo | DN st of working | 18b. KIND OF BUS | | |
| COMPLET | 12 17. FATHER'S NAME (First, Middle, Lest) | 1 | Agent | | | ME (First, Middle, Maiden | Surname) | 0. |
| TO BE | John Edward Mc | | | | nd Number or Rural | ne Edwards Route Number, City or Town | | |
| | Sharon Mc: Kensi 29. METHOD OF DISPOSITION 1A Burlat 2 Cremetion 3 Remo | 20b | PLACE AND DATE OF DISI etery, crematory or other pla rostburg Me | POSITION (Na | me of | | CATION — City of | or Town, Stata |
| | 21. SIGNATURE OF PUNERAL SERVICE LICE | | | 22. NAME AN | D ADDRESS OF FA | | stburg | |
| | 23. PARD . Enter the diseases, or conshock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death) | omplications that caused lat only one cause on each of the cause on each of the cause of the cau | tha death. Do not enach lina. | ter tha mo | de of dying, auc | h as cardiac or respi | ratory arrest, | Approximate Interval Batweer Onset and Death |
| CERTIFICATION | Sequantially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF): | Cer | livase | cler | Due | ese |
| MEDICAL | PART II. Other algorificant conditions DID TOBACCO USE CONTR | | | | | PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| H TSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 28. PLACE OF DEATH (Che | ck only one) | | | | |
| BY PHY | 27. MANNER OF DEATH 1 Netural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJ WO | JRY AT RK? | XOther (Specify) Re 28d. DESCRIBE HOW II | | |
| | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide datarminad | 28s. PLACE OF INJURY building, atc. (Spec | At home, farm, street, | factory, office | | 261. LOCATION (Street a City or Town, State) | and Number or Ru | unal Route Number, |
| COMPLEIED | | CIAN: To the best of my knowl | | | | | | use(s) and manner as stated. |
| 2 2 2 | 280. SCHOOLINE AND TITLE OF CENTIFIER | orle | MO | | O.C.M | | 29d. DATE SIG | NED (Month, Day, Year) |
| - | 30. NAME AND ADDRESS OF PERSON WHO | OCKEMD 1 | 11 Penn S | tree | | imore, M | | |
| | AUG 2 2 1994 | 32. REGISTRAR'S SIGNA | ATURE OF ROLLING | <u></u> | | | | |

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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within embours after death. Page | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral di | |
| after | y the | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
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IMPORTANT: It Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR

| | 1 - STATE REGISTRAR | OF MARTE | CERTIF | | | | | MENI | REG. NO. | Ė | | |
|---------------|---|---|------------------------------|------------------------|------------------|-----------------|-----------|-----------|----------------------------------|-----------|-------------------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DAT | E OF DEATH | | YEAR | 3. TIME OF DEATH |
| | VIRGINIA | MIL | LS | | | | | 0 | | - | 94 | 6.45 AH |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | | (In yrs. last birthday) | IF UNDER | DAYS | IF UNDER | 24 HRS. | | E OF BIRTH | | Country | PLACE (State or Foreign |
| | 216-05-7229 1 M 2 | | 5 YRS. | | | HOOMS | | 6/2 | 25719 | | Mar | yland |
| ~ | 9a. FACILITY NAME (If not institution, give street and nur | | | l | , TOWN O | | | | | | INTY OF DE | |
| Ď | Northwest Hospital | Cente | r | Randallstown | | | | | | В | alti | more |
| DIRECTOR | 10a. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN C | OR LOCATI | ON | | | | | | 10d. INSIDE CITY |
| | MD Carroll | | 1 | vest | min | ste | r | | | | | LIMITS? 1 YES 2 NO |
| AL | 10e. STREET AND NUMBER | | | | 101. | ZIP COD | E | | | 10g. CIT | IZEN OF W | HAT COUNTRY? |
| E | 1304 High Ridge Dr | ive | | | | 211! | 57 | | | U | nite | d States |
| BY FUNERAL | 1 V Never Married 2 Married FORCE | ECEDENT EVER II S? 1 TYES GIVE WAR OR D | 2 NO | | | city Cube | n, Maxica | n, Puerlo | IN? (Specify Yes Rican, etc.) | or No | 14. RACE Black, Specify | - American Indian, White, etc. |
| | 15. DECEDENT'S EDUCATION | | 18a. DECEDENT'S | USUAL O | CCUPATIO | N | | 16 | b. KIND OF BUS | INESS/IN | DUSTRY | |
| H. | (Specify only highest grade completed) Elementary/Secondary (0-12) College (| I-4 or 5+) | (Give kind of life. Do NOT u | work done is retired.) | during mos | t of worki | ng | | | | | |
| MP. | | | worke | r | | | | _ 1 | rector | y/c | hurc | h |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOT | HER'S NA | ME (First | Middle, Maiden | Surname) | | |
| BE | Walter R. Mills | | | | | _ | eres | | | | Germ | uth |
| [일 | 19e, INFORMANT'S NAME (Type/Print) | | | | | | | | mber, City or Town | | | .m. 0116 |
| | Walter Mills 200. METHOD OF DISPOSITION | | | | | | | | | | | r, MD 2115 |
| | 1 Buriel 2 Cremetion 3 Removal from S | CON | PLACEAND DATE | mer precel | | | | 4 | | | nore | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | 22. | NAME AN | D ADDRE | SS OF FA | CILITY | | | | |
| | * Yathani Pich | 0 - Vu | witness | | | | | | Home | | | |
| \neg | 23. PART I. Enter the diseeses, or complication | one that ceuse | d the Seath. Do | not enter | the mod | was le of dy | ing, suc | TEO! | rdiac or reapi | ratory ar | SCIIII) reat, | nster, MD |
| | ehock, or heart fellure. List only one cause on asch line. | | | | | | | | | | interval Between Onset and Death | |
| | disease or condition | | | | | | | | | | YWEEK | |
| | resulting in death) | DUE TO (OR AS | CONSEQUENCE O | F): | | | | | | | | 7 1000 |
| Z | Sequentially list conditions, | RESP | CONSEQUENCE | M | FF | 1111 | JRE | , | | | | MUGERS |
| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | DUÉ TO (OR AS A | CONSEQUENCE O | F): | | | | | | | | |
| 일 | CAUSE (Disesse or injury | DUE TO JOR AS J | CONSEQUENCE O | E). | | | | | | | | |
| Ē | that initiated eventa resulting in deeth) LAST | 30L 10 (011 NO) | OUNDEDDENCE O | · /· | | | | | | | | i |
| S | d | | | | | | | | | | | 1 |
| AL | PART II. Other significent conditione contribu | | | | | | | Part I. | 24a. WAS AN | | | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO |
| MEDICAL | DEMENTIA, COPO | IAR | KINSOM | 12 E | 712E | ASE | | | 1 TYES 2 | NO | | COMPLETION OF CAUSE OF DEATH? |
| ME | DID TODA GGO HOT GOVERN | | | | | | | | | | | 1 TES 2 NO |
| PHYSICIAN: | DID TOBACCO USE CONTRI | BUTE TO | CAUSE OF | DEAT | H YE | S 🗀 | NO | | | | | |
| 2 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | OTHER | | ACE OF D | EATH (Ch | eck only | one) | | | |
| tYS | | ant 2 - ER/Ouf | patient 3 DOA 28b, TIN | | | | esidenca | - | ter (Specify) | | | |
| | 1 SeNeturel 5 Pending | Month, Day, Year) | | JURY | 28c. INJL WOI | RK? ES 2 | T NO | 28d. D | EŞCRIBE HOW IN | IJURY OC | CURED | |
| ВУ | 2 Accident Investigation 3 Suicide 8 Could not be 28e. | PLACE OF INJURY | - At home, farm, | etreet, fact | | | _ 140 | 281 10 | CATION (Street a | nd Numbe | y or Aural Br | nuto Numbro |
| COMPLETED | 4 Homicide determined | building, atc. (Spe | cify) | | | | | | y or Town, State) | no Ivamba | or moral no | na rumoer, |
| 삗 | 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the | heet of my know | ladge death occur | ad at the t | the data | | | an abo - | | bee 6 | | |
| M P | (Check only one) 2 MEDICAL EXAMINER: On the b | | | | | | | | | | | and manner as stated |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | , | 1 | | | | | | | |
| BE | - Della P | 001 | 200 | | | TAC FICE | ENSE NUI | WEER | , [| 29d. DA | SIGNED | (Month, Day, Year) |
| 2 | 30. NAME AND EDDRESS OF PERSON WHO COMPLET | ED CAUSE OF DE | ATH (ITEM 27) (Tons | . Print1 | | U | 411 | 11 | J | (| 18,9 | 13-74 |
| | - shallbe us | | | | Innta. | | 0 | 4011 | a.l. ~ = | 4.4 | .I | |
| | 31. DATE FILED (Month, Day, Year) 32. R | EGISTRAR'S SIGN | ST HOSD | ITCU (| enic | — | ran | 1011 | stown, | M | 1 | |
| | AUG26 1994 | vivolen A | ardall | | | | | | | | | |

| ge. | Q. | | - |
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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral dire | | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner |
| after | y the | be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to bunal, cremation, or removal. | cal |
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Freema

RICHARD FREEMAN

AUG 2 6 1994

31. DATE FILED (Month, Day, Year)

Richard Freeman, M.D.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M.D.

32, REGISTRAR'S SIGNATURE

Davidson Randall

ctor,

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 2. DATE OF DEATH MONTH 1. DECEDENT'S NAME (First Middle Last) 3. TIME OF DEATH 2 2 9 YEAR FRANK MUFFOLETTO 5:00A 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 1/16/29 6. AGE (In yrs. last birthday, IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign Country) IF UNDER 24 HRS. DAYS 217244117 1 🕅 M 2 🗆 F 65 MARYLAND 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Perry Point VA Med. Center Cecil Perry Point, Md. 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Harford White Hall t TYES 2 NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 2533A Bradenbaugh Road 21161 U.S.A. 12. WAS DECEDENT FYER IN U.S. ARMED FORCES? 1 YES 2 □ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuben, Maxican, Puarto Rican, atc.)
1 YES 2 NO Specify: RACE — American Indian, Black, White, atc. 1 Never Married 2 M Married B⊀ Specify: 3 Widowed 4 Divorced Korea Caucasian COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 8 Stone Mason Construction 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Muffoletto must be notified at Samuel Lucia BE Provenza 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Grace C. Muffoletto #10 same as 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State cemetery, cremators or other place)
Carroll Cremation 8/26 Hampstead. Maryland examiner 21. SIGNATURE OF PUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Kurtz Funeral Home Denfomen Murch Jarrettsville. Maryland medical 23. PART I. Enjer/the diseases, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate shook, or heert fallure. List only one ca interval Between use on each line. IMMEDIATE CAUSE (Final Onset and Death other traumatic event, the disease or condition_ cancer DUE TO (OR AS A CONSEQUENCE OF): resulting in death) CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST 23 shows any injury, or PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 X YES 2 NO OF DEATH? 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Item HOSPITAL OTHER: 1 TYES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident t TYES 2 NO BY 28a. PLACE OF INJURY — At home, term, street, factory, office building, stc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a, CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: Of the ation and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TIME OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

D37065

Perry Point VA Medical Center

DHMH-18 Rev 1/89

8/24/94

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FOR 1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

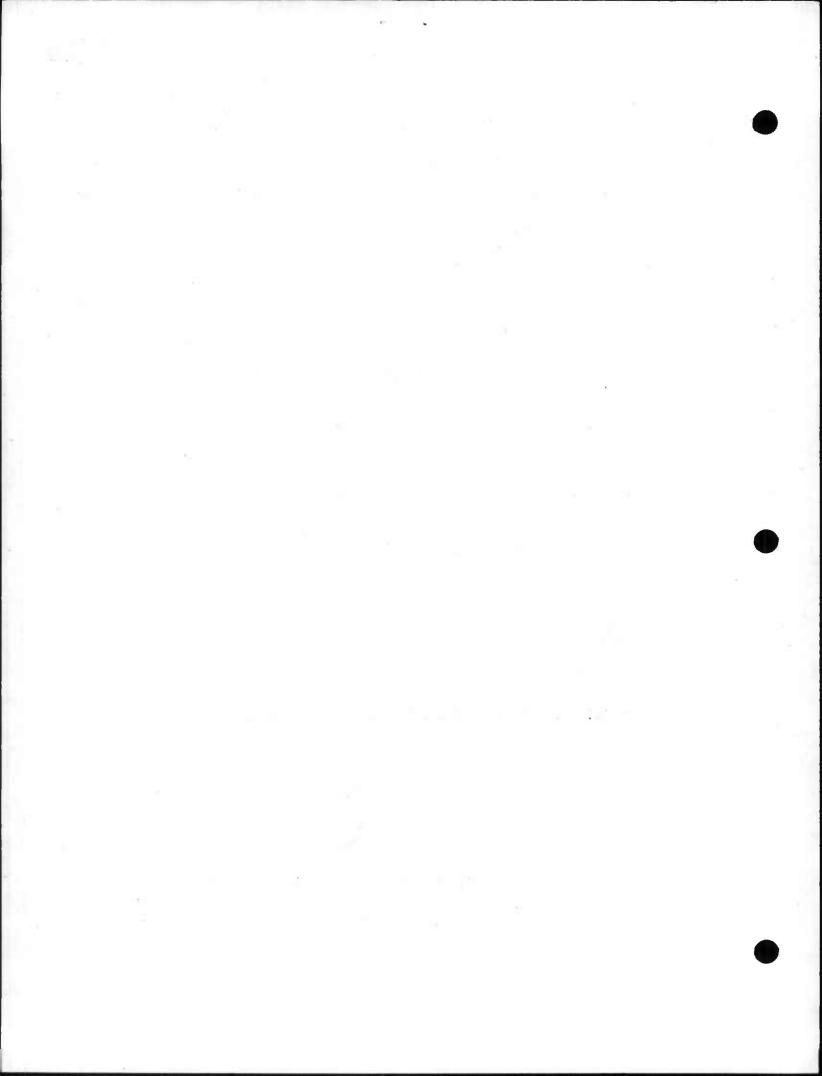
| | REGISTRAR | | CERTIFIC | CATEO | F DEATH | RE | G. NO. | | |
|--|--|---|--|-----------------|---|-------------------------------|--------------------|-------------|---|
| , | 1. DECEDENT'S NAME (First, Middle, Last) | Gladys Edwar | ds Mitch | e11 | | 2. DATE OF DE | 23, 19 | 94EAR | 3. TIME OF DEATH 3:17 A M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (In | _ | F UNDER 1 YEAR | | 7. DATE OF BH (Month, Day, | нтн | | IPLACE (State or Foreign |
| i | 171-26-3485 | 1 ☐ M 2 🔀 F | 81 YRS. | ONTHS DAYS | HOURS MIN. | 02-01 | -1913 | Count | " PA |
| _ | 9e. FACILITY NAME (If not institution, give s | | 9 | b. CITY, TOW | OR LOCATION OF D | EATH | 9c. COU | NTY OF D | |
| DIRECTOR | Harford Memori | al Hospital | | H | avre de | Grace | | Ha | rford |
| Ų Ų | 10e. STATE 10b. COUNT | Y | 10c. CITY, | TOWN OR LO | ATION | | | | 10d. INSIDE CITY LIMITS? |
| | | larford | | H | avre de | Grace | | | 1 X YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER | D-: #0D | | | IOF. ZIP CODE | | 10g. CIT | | WHAT COUNTRY? |
| Ž | 1034 Chesapeak | | | | 21078 | | | US | |
| | 1 Never Merried 2 Merried | 12. WAS DECEDENT EVER IN FORCES? 1 YES | 2 XNO | If yes, | ECENDENT OF HISPA specify Cuban, Mexic | en, Puerto Ricen, | | Biaci | E — Americen Indien, k, White, etc. |
| à | 3 X Widowed 4 Divorced | IF YES, GIVE WAN ON DAI | ies | 1 '0' | ES 2 X NO Speci | γ. | | Speci | White |
| | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 16a. DECEDENT'S US (Give kind of wor | k done during | TION most of working | 16b. KIND | OF BUSINESS/INC | JUSTRY | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+) | ille. Do NOT use | | • | ١, | (Taamital | | |
| N N | 17. FATHER'S NAME (First, Middle, Lest) | | Nurs | es Aid | | ME (First, Middle, | Hospital | | |
| | Arthur Mich | ael Edwards | | | W | lary Mc | | | |
| O BE | 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAILING A | DDRESS (Stree | t and Number or Rural | | | Code) | 21078 |
| - | Mrs. Dianne Mitc | | 1034 | Chesaj | eake Dr | #8D, | Havre d | le G | |
| | 20e, METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Rem | | PLACE AND DATE OF tery, crematory or othe | r place) | | | 20c. LOCATION — | | |
| | 4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIG | A | ngel Hill | Ceme | tery | | Havre (| <u>de G</u> | race, MD |
| ĺ | M. 1m. 9 | | | Mitc | hell-Smit | h Fune: | | | |
| | 23. PART i. Enter the disesses, or | complications that saured | the death. Do not | | re de Gr | | | | |
| | shock, or haart fallura. | List only one cause on as | ch ilna. | contai tire i | loca of dying, suc | ir an Cardisc C | i respiretory ari | est, | Approximata Interval Between |
| | iMMEDIATE CAUSE (Final disease or condition | Ventrymy | n or Vo | SUIS | c 4 | BDSIL. | | | Onset and Daath |
| Ì | resulting in dasth) | DUIL TO (OR AS A | CONSEQUENCE OF): | ,() | | 177 | | | |
| 5 | Sequentially list conditions, | b | | | | | | | |
| CERTIFICATION | if sny, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A (| CONSEQUENCE OF): | | | | | | |
| <u> </u> | CAUSE (Disease or Injury that Initiated avants | C. DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | |
| | resulting In death) LAST | d | | | | | | | |
| 2 | PART II. Other eignificant condition | ns contributing to death bu | t not resulting in | tha undarly | ng cause given in | Part i 24a | WAS AN AUTOPSY | 245 | . WERE AUTOPSY FINDINGS |
| 3 | | _ | | | ng cooo gnan n | | PERFORMED? | *** | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDI | | | | | | '' | YES 2 NO | | OF DEATH? |
| | DID TOBACCO USE C | CONTRIBUTE TO | CAUSE OF I | DEATH | YES NO | | | | TO TES ZONO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSBITAL | | | PLACE OF DEATH (CI | neck only one) | | | |
| 0 | 1 TYES 2 X NO | HOSPITAL: 1X Inpatient 2 - ER/Outpat | tient 3 DOA 4 | OTHER: | ome 5 🗆 Residence | 8 C Other (Spec | oHy) | | |
| 5 | 27. MANNER OF DEATH 1 X Natural 5 Pending | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME (| TY ! | NJURY AT VORK? | 28d. DESCRIBE | HOW INJURY OC | CURED | |
| ā | 2 Accident Investigation | 28e. PLACE OF INJURY - | - At home, ferm, str. | | YES 2 NO | 28f LOCATION | (Street end Number | or Reveal I | South Millionhay |
| | 4 Homicide 8 Could not be determined | building, atc. (Specif | (v) | , , , , , , , , | | City or Tow | n, State) | or nover r | House Mulhosi, |
| ֓֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֓֡֓֓֓֓֓֓֡֓֡֓ | 29e. CERTIFIER 1 X CERTIFYING PHYSI | ICIAN: To the best of my knowle | dge, death occurred | at the Ilme, di | ite end place, end du | to the cause(e) | end menner ee atal | ted. | |
| COMPLE | | R: On the basis of examination | | | | | | | e) end menner ee stated. |
| - 13 | 29b. SIGNATURE AND TITLE OF CERTIFIE | A (1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1- | | 1 | 29c. LICENSE NU | MBER | 296, DAT | E PIONED | (Morth, Dep. Year) |
| | r . | Manh | y ann | ′ | 10460 | 12 | ▶ 8 | 23 | 194 |
| - | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF DEAT | TH (ITEM 27) (Type, P | DE 1 | ippe | mn | 2/070 | 1 | |
| | 31. DATE FILED (Month, Day, Year) | 32. BEGISTRAR'S SIGNA | | , | Trans. | , | 11 | | |
| | AUG 2 5 1994 | Julia Davidson | Mardall | | | | 7 | | - 1 |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within how in the redain. Page 5 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

DHMH-16 Rev 1/89



| BALTIMORE, MARYLAND 21215-0020 | nours after death. Page 6 may be retained by the hospital or attending physician. | illed in by the funeral director, page 5 should be detached for use as the burial-trans. n, or removal. | e medical examiner must be notified at once. |
|---|---|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Thours after death. Page 6 may be retained by the hospital or attending physiciain. | TO THE FUNERAL DIRECTOR: After this cardificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transfer be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG, NO. |
|---------------|---|
| | 1. DECEDENT'S NAME (First, Middle, List) EOA Marshall 2. Date of Death Month DAY Hugust 21, 1994 3. TIME OF DEATH MONTH Hugust 21, 1994 3. Z6 pm 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTN 6. SIRTNPLACE (State or Foreign |
| | 219-07-2832 1 M 2 MF 76 YRS. MONTHS DAYS HOURS MIN. 6-23-1918 |
| OR | PENINSULA REGIONAL MEDICAL CENTER SALISBURY 96. CITY, TOWN OR LOCATION OF DEATH SALISBURY WICOMICO |
| DIRECTOR | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CNTY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? |
| | MD WORCHESTER TOCOMOKE 100. STREET AND NUMBER 101. ZIP CODE 109. CITIZEN OF WHAT COUNTRY? |
| FUNERAL | 3118 WORCETER HWY 21851 U.S |
| B√ | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No-II yea, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, Whita, etc. 15. Yes, GIVE WAR OR DATES 16. Yes 2 No Specify: |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY 16b. KIND OF BUSINESS/INDUSTRY |
| | 17. FATHER'S NAME (First, Middle, Last) OT:S MARShall KOSE And W:SE |
| TO BE | 190. INFORMANT'S NAME (Type-Print) MADE! NE BLAKE 190. MAILING ADDRESS (Street and Number or Parall Bodge Number, City or Town, State, Zip Code) MADE! NE BLAKE 190. MAILING ADDRESS (Street and Number or Parall Bodge Number, City or Town, State, Zip Code) |
| | 20e. METHOD OF DISPOSITION 1 M Burisi 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE ANDDATE OF DISPOSITION (Name of Complete, Credible) of other pace) M. JAN DAPIST Chuich 8/38/41 ARD TOWN, MD. |
| | 21. SIGNATURE OF JUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ANTONY E. WARD TUNGRAL HOME 30639 HAMPDEN AVE PRINCES AME, MD. 21853 |
| | 23. PART. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, interval Between Onset and Death Onset and Death Onset and Death Out To (or as a consequence of): |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. |
| EDICAL | PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24e. WAS AN AUTOPSY PREFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AWALABLE PRIOR TO COMPLETION DE CAUSE OF DEATH? 1 YES 2 NO |
| N. W | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO |
| PHY | 27. MANNER OF DEATH 28a. DATE OF INJURY (Morth. Day, Year) 28b. TIME OF INJURY (Morth. Day, Year) 28c. INJURY WORK? 28d. DESCRIBE HOW INJURY OCCURED |
| BY | 2 Accident Investigation Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, office 28f, LOCATION (Street and Number or Burel Route Number) |
| ETEC | 3 Suicide 8 Could not be 4 Homicide determined Suitiding, etc. (Specify) |
| COMPLETED | 29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(a) and manner as stated. Discretely the control of the cause(a) and manner as stated. |
| ш | 29b. SIGNATURE AND TITLE OF CENTERIES 29d. DATE SIGNED (Month, Day Year) |
| TO B | 30. (AME AND DORESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) |
| | Jeffrey Wieland 560 Riverside Dr. Salisbury MD 21801 |
| | 31. DATE FILED (Mornin, Day, Year) 72, REGISTRAN SIGNATURE |

H * L. L. - . 17 75 To a second second Established your life. Track March 1997 on a " The say" when we show the

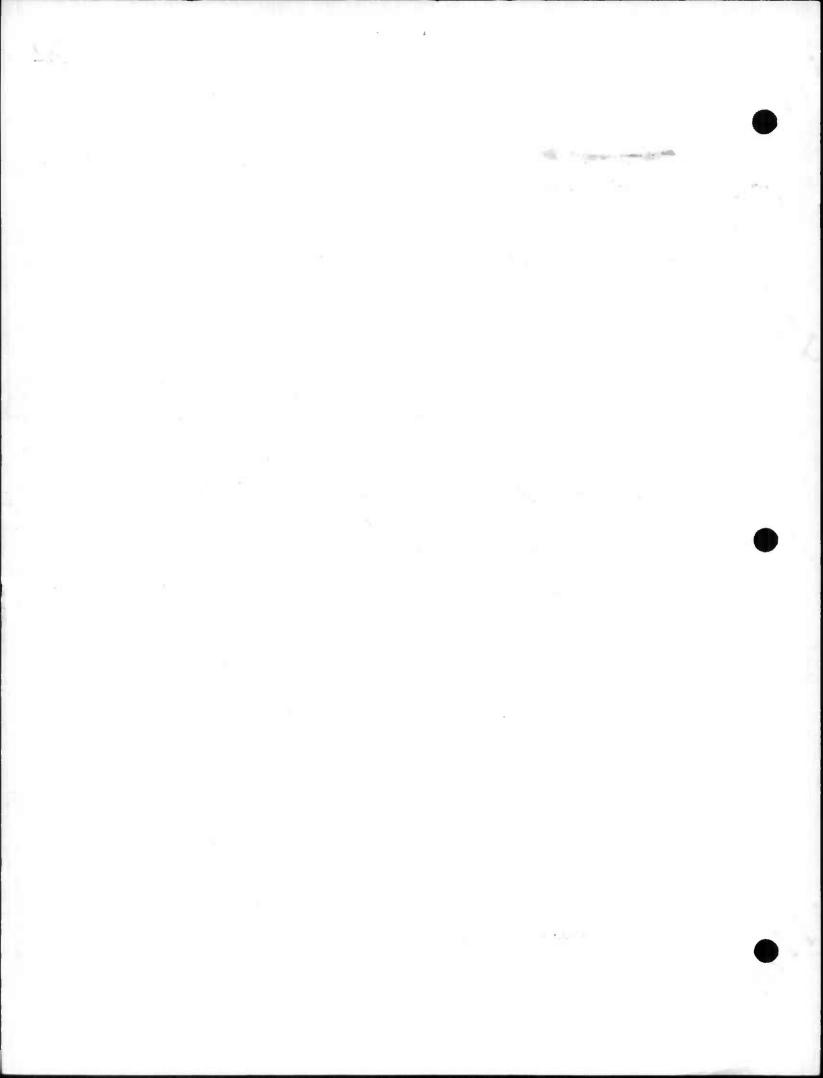
| 1 | - | FOR STATE REGISTRA |
|---|---|--------------------------|
| | | |

STATE OF MARYLAND / OEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1 - REGISTRAR | | CERTIF | ICATE OF | DEATH | REG. N | Ю. | | |
|---------------|--|--|--|---|---|---|------------------------------|-------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last)Ma | | Mason | | | 2. DATE OF DEATH | DAY 9 | YEAR | 3. TIME OF DEATH |
| | 219-72-3874 | □ M 2 4 F | n yrs. last birthday) 37 YRS. | MONTHS DAYS | HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 12/10/1 | 956 | Was | h. DC |
| TOR | 96. FACILITY NAME (If not institution, give street University Hospi | tal | | Balti | OR LOCATION OF DE | EATH | | timo | |
| DIRECTOR | 10s. STATE 10s. COUNTY | e Geaorge | | y, town on Loca on Hil | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 XNO |
| FUNERAL | 705 Irvington St | . Apt. 20 |)1 | | 01. ZIP CODE 20745 | | | S.A. | HAT COUNTRY? |
| Β¥ | 11. MARITAL STATUS 12 1 Never Married 2 Married 3 Wildowed 4 Divorced | P. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 7 NO | If yea, a | CENDENT OF HISPAN pecify Cuban, Maxica S 2 NO Specifi | NIC ORIGIN? (Specify in, Puerlo Rican, etc.) y: | Yas or No- | Black, | - American Indian, White, atc. Black |
| 딢 | 15. DECEDENT'S EDUCATI (Specify only highest grade com | ION npleted) | 16a. DECEDENT'S (Give kind of v | USUAL OCCUPAT work done during man retired.) | ION lost of working | 16b. KIND OF I | SUSINESS/IND | | |
| COMPLETED | Elemegrary/Secondary (0-12) | College (1-4 or 5+) | Home H | | | Nu | ırsin | g | |
| BE CO | 17. FATHER'S NAME (First, Middle, Last) Lewis Mason | | | | | Me (First, Middle, Mald Jenkins | | | |
| TO . | 19a. INFORMANT'S NAME (Type/Print) Alice Mason | | 196. MAILING 8890 | ADDRESS (Street Chapel | Pt. Rd | . BelAlt | own, State, Zip | D 20 | 611 |
| | 20e_METHOD OF DISPOSITION 1 | I from State 20b. cem | PLACE AND DATE OF PLACE AND DA | ther place) | em. 8/2 | | LOCATION — | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENS David C. Edu | | 00945 | AREH | ND ADDRESS OF FA | OLS FUNI | | | |
| N | 23. PART I. Enter the diseases, or com- shock, or heart failure. List IMMEDIATE CAUSE (Finst disease or condition resulting in death) Sequentially list conditions, | Cardin pu | the death. Do nach line. | Cibal Cibal And A | ode of dying, suc | h sa cardiec or re | ipiratory err | rea1, | Approximate Interval Between Onset and Death |
| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | Hypuka | CONSEQUENCE OF | | | | | | |
| MEDICAL | PART II. Other algnificant conditions of | | | | | PERF | AN AUTOPSY ORMED? 2 NO | | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| Z | DID TOBACCO USE CO | NTRIBUTE TO | CAUSE OF | | | | | | |
| <u>5</u> | EXAMINER? | OSPITAL: | T. W D 1 | OTHER: | PLACE OF DEATH (Ch | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH 1 Netural 5 Pending | Inpetiant 2 ER/Outp 28a. DATE OF INJURY (Month, Day, Year) | 28b, TIM | E OF 26c. IN | me 5 Residence JURY AT ORK? YES 2 NO | 6 Other (Specify) 28d. DESCRIBE HO | V INJURY OCC | CURED | |
| TED BY | 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined | 28s. PLACE OF INJURY building, stc. (Speci | — At home, larm, s | | | 281. LOCATION (Stre City or Town, Ste | et and Number | or Rural Ad | oute Number, |
| COMPLET | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAL ONE) 2 MEDICAL EXAMINER: C | | | | | | | | and manner as stated. |
| BE | 296. SIGNATURE AND TITLE OF SERTIFIER | MN | | | 29c. LICENSE NUI | | 29d. DATE | E SIGNED | (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO C | OMPLETED CAUSE OF DE | ATH (ITEM 27) (Type, | Print), M/f | 3 A-3 m | S Green | 5-1 | 1-2 | 8/ |
| | 31. DATE FILED (Month, Day, Year) AUG 2 4 1994 | 32. DECISTRAR'S SIGN | ATURES OF RONDOLL | | 1/100/ | 10120) | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

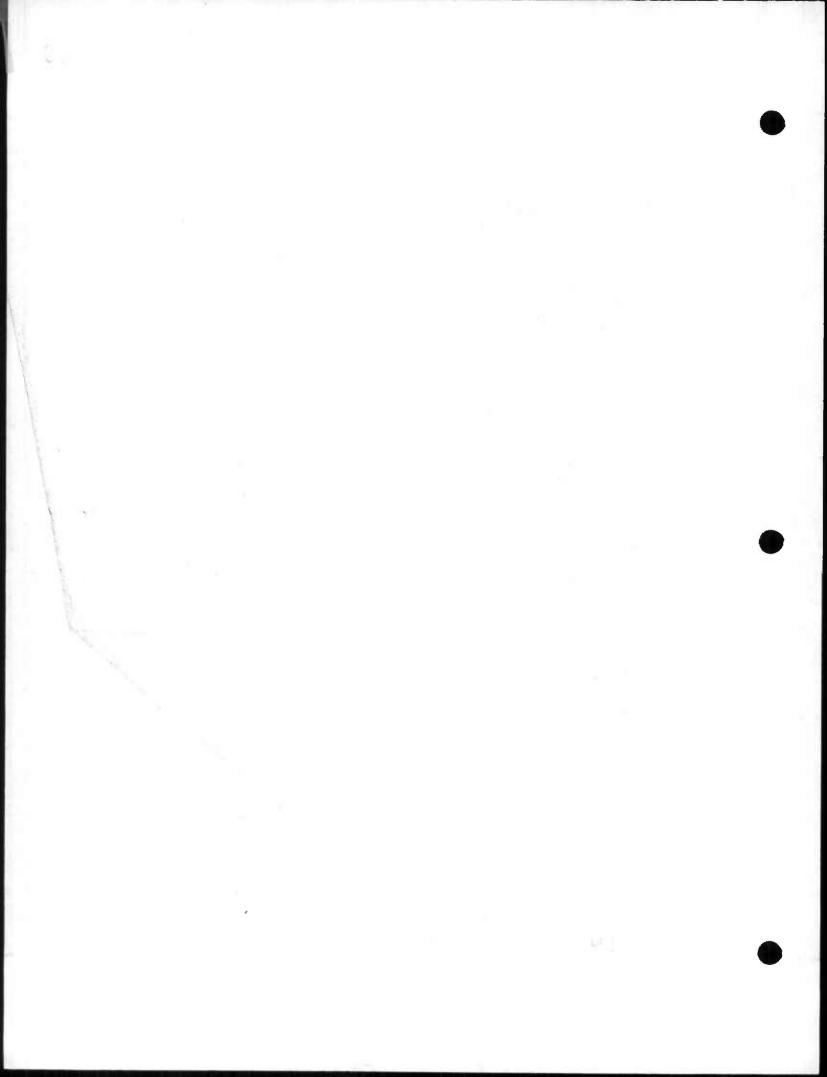
DHMH-18 Rev 1/89



DIVISION OF VITAL RECORDS, P.O. BOX 68760

item 28 is marked, or item 23 shows any Injury, or other traumatic PLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| - 1 | 1. DECEDENT'S NAME (First | , Middle, Last) | Paul H | H. Mey | ers | | | | DATE OF DEATH DATE OF DA | | YEAR | 10:00 P M |
|---------------|--|--------------------------|--|---------------------------------------|---|-----------------|-------------------------------------|----------|--|-------------|------------------------------------|--|
| | 4. SOCIAL SECURITY NUMBER 168-24-2857 | | | 8. AGE (In yrs. les | t birthday) | IF UNDER 1 YEAR | | rRS. 7. | DATE OF BIRTH | | | |
| OR | 90. FACILITY NAME (# not # | den Vie | | | | | n or Location | OF DEATH | | | ty of DEAT Shing | н |
| DIRECTOR | nesidence of dec 100. STATE Maryland | 10b. COUNTY | hington | | | town on Lo | | | | | | d, INSIDE CITY LIMITS? YES 2 💆 NO |
| FUNERAL | 100. STREET AND NUMBER | | iew Road | | | | 101. ZIP CODE 2174 | 0 | | | S.A. | T COUNTRY? |
| B | 11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Dive | | 12. WAS DECEDENT FORCES? 1 IF YES, GIVE WA | YES 2 N | | If yes | , specify Cuben, N | | PRIGIN? (Specify Yea uarto Rican, etc.) | or No— | 14. RACE — Black, W Specify: | American Indian, hite, etc. White |
| COMPLETED | | by highest grade (0-12) | | (G life. | Do NOT use | | ATION most of working entativ | e | Busine | | | ompany |
| BE CON | 17. FATHER'S NAME (First, A | | ry S. Mey | yers | | | | | First, Middle, Maiden a Cline | Surname) | | |
| 5 | 190. INFORMANT'S NAME (Type/Print) Mark S. Meyers 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1316 Hamilton Blvd. Hagerstown, Md. 2174 | | | | | | | | | 42 | | |
| | 20c. METHOD OF DISPOSITION 1 P. Burlel 2 Cremetton 3 Removal from State 4 Donatton 5 Other (Specify) 20b. PLACE AND DATE Of DISPOSITION (Name of Certain Control o | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE A Martin Zumuerum T Zimmerman And Son Funeral Home Greencastle, Pa. 17225 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | | |
| | | naart fallure. I nal | a. HEPAT | e on aach lins | | | | | a cardiac or respi | ratory arre | est, | Approximate Interval Between Onset and Daath |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| MEDICAL CER | CORONARY ARTERY DISEASE 1 YES 25 NO OF | | | | | | | | ERE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE F DEATH? | | | |
| PHYSICIAN: M | DID TOBACO | | CONTRIBUTI | TO CAL | | | YES T | NO | only one) | | | |
| IXSI | 1 TYES 2 NO | | 1 Inpetient 2 I | · · · · · · · · · · · · · · · · · · · | | € Nursing | Home 5 Reeld | | Other (Specify) d. DESCRIBE HOW I | NJURY OCC | URED | |
| BY P | 1 Natural 5 🗆 2 🔲 Accident | Pending Investigation | (Month, Da | | імли | RY M 1 | WORK? | 10 | f. LOCATION (Street | | | ta Number |
| ETED | 3 Suicide 6 4 Homicide | Could not be determined | building, e | etc. (Specify) | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | City or Town, State, | | or rural root | w ivanison, |
| COMPLETED | CONSTRUCTION OF THE CONSTR | | CIAN: To the best of i | | | | | | | | | nd manner ee stated. |
| TO BE (| 29b. SIGNATURE AND TITL 30. NAME AND ADDRESS O | Tope | Bradlo | al in | | | 29c. LICENS | _ | R | 29d. DATE | 26 C | onth, Day, Year) |
| | A man | SK BA | HOPORD, | MAS SIGNATURE | M 27) (Type, 1 | House | eu RS | | HAGER | 570L | IN, M | 18 21780 |
| J. | AUG 2 91 | | 1 | en Handa | UL. | | | | | | | |



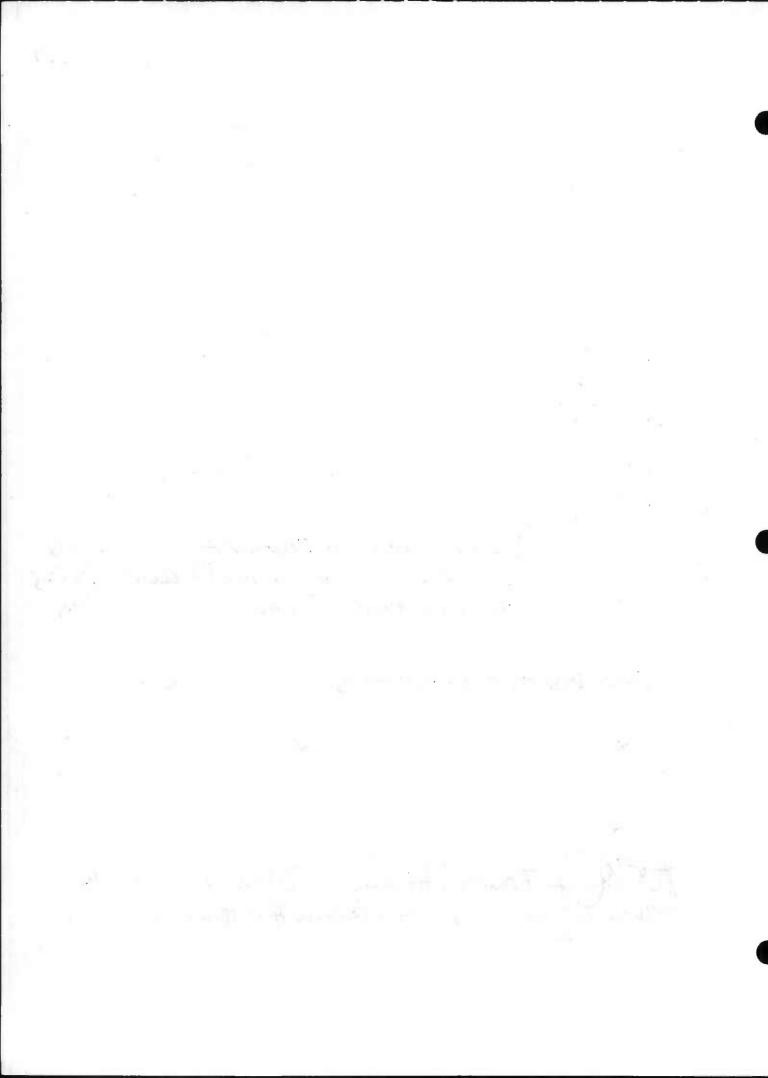
FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1 - STATE REGISTRAR | | CATE OF | DEATH | REG. NO | | | | | | | |
|------------------|--|-------------------------------------|-----------------------------------|----------------------|--|----------------|----------------------------|---|--|--|--|--|
| 9 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | | 3. TIME OF DEATH | | | | |
| 0 | May Lorraine Moats | | | | | 24 1 | 994 | м | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In y | rs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | 8. BIRTH | PLACE (State or Foreign | | | | |
| | 215-18-2455 1□ № 2 🖼 ៛ 73 | YRS. | MONTHS DAYS | HOURS MIN. | June 23, | 1021 | Countr | y) | | | | |
| - 6 | 9a. FACILITY NAME (If not institution, give street and number) | | 9b. CITY, TOWN C | R LOCATION OF DE | | | MATY OF D | ryland EATH | | | | |
| TOR | 317 South Potomac Street | | Hagers | stown | | Washington | | | | | | |
| E | 10s. STATE 10b. COUNTY | 10c. CITY | , TOWN OR LOCAT | ION | | | | 10d, INSIDE CITY | | | | |
| E | Maryland Washington | Ha | gerstown | 1 | | | - 1 | LIMITS? | | | | |
| 7 | 10e. STREET AND NUMBER | | - | ZIP CODE | | 10g, CITI | ZEN OF V | WHAT COUNTRY? | | | | |
| FUNERAL DIRECTOR | 317 South Potomac Street | | | 21740 | | | S.A. | | | | | |
| ВУ | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 X Widowed 4 Divorced 12. WAS DECEDENT EVER IN U. FORCES? 1 YES: IF YES, GIVE WAR OR DATE | 2 NO | If yea, sp | | NIC ORIGIN? (Specify Ya in, Puerte Rican, etc.) | a or No | 14, RACE Black Speci | - American Indian, t, White, atc. | | | | |
| | 15. DECEDENT'S EDUCATION 16 | a. DECEDENT'S | USUAL OCCUPATION | IN . | 16b. KIND OF BU | SINESS/IND | USTRY | *************************************** | | | | |
| COMPLETED | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | (Give kind of w life. Do NOT use | ork done during mo e retired.) | st of working | | | | | | | | |
| 립 | | Sales C | lerk | | Gift & | Card | Sho | q | | | | |
| 0 | 17. FATHER'S NAME (First, Middle, Last) | | | 18. MOTHER'S NA | ME (First, Middle, Maiden | Sumame) | | | | | | |
| BE C | Mentor Purdue Bachtell | | | Lupha | H. Shantz | | | | | | | |
| | 19e. INFORMANT'S NAME (Type/Print) | 19b. MAILING | ADDRESS (Street a | nd Number or Rural I | Route Number, City or Tox | vn, State, Zip | Code) | | | | | |
| 6 | Ronald F. Moats | 5002 | Red Hill | . Road Ke | edysville | . Mar | vlan | d 21756 | | | | |
| | 20s. METHOD OF DISPOSITION 20b. PL | ACEANDDATEO | F DISPOSITION (Ne | | | CATION - | | | | | | |
| | 1 Buriel 2 Cremation 3 Removal from State 4 Donalion 5 Other (Specify) | ry, crematory or oti ar Laen | Memoria | l Park 8 | 3-27-1994 | Hage | rsto | wn. Maryland | | | | |
| | 21. MIGHATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AN | D ADDRESS OF FA | CILITY 1221 | _ | | lvd. North | | | | |
| | > I James N. France | | _ | s A. Fie | 1 | | | | | | | |
| \dashv | 23. PAR I. Enter the disease, or complications the coused the | ne deeth. Do n | Funera | Home | hagersto | WII, M | aryı | | | | | |
| | 23. PAR I. Enter the disease, or complications the Caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Onest and Death | | | | | | | | | | | |
| z | DUE TO (OR AS A CONSEQUENCE OF): CEUNE (SET (KINGGE) AT FAYOURGE MICHAELE | | | | | | | | | | | |
| CERTIFICATION | If any, leading to immediate | | | | | | | | | | | |
| 2 | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury c. SCHCAMCC HOATT DCSCATE) | | | | | | | | | | | |
| Ë | CAUSE (Disease or Injury thet initiated events resulting in deeth) LAST | | | | | | | | | | | |
| Ы | | | | | | | | | | | | |
| الد | PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | | | | |
| DICAL | HUGIOTHARIOT LUT | RIN | ALK | | PERFO | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | | |
| 밀 | 710 | | | 7 | | OF DEATH? | | | | | | |
| - | | | | | _ | | | | | | | |
| Y | 25. WAS CASE REFERRED TO MEDICAL | | 26. PL | ACE OF DEATH (Ch | eck only one) | | | | | | | |
| Sic | EXAMINER? 1 YES 2 NO 1 Inpetion 2 ER/Outpetic | nt 3 DOA | OTHER: | | 8 Other (Specify) | | | | | | | |
| PHYSICIAN: MEI | 27. MANNER OF DEATH 28s. DATE OF INJURY | 28b. TIME | OF 28c. INJ | | 28d. DESCRIBE HOW | INJURY OCC | CURED | | | | | |
| | 1 Return 5 Pending (Month, Day, Year) 2 Accident Investigation | INJU | | RK? 'ES 2 NO | | | | | | | | |
| ВУ | 3 Suicide 28e. PLACE OF INJURY — | At home, ferm, a | treel, lactory, office | | 281. LOCATION (Street | | or Rural F | loute Number, | | | | |
| Ĕ | 4 Homicide determined building, etc. (Specify) | | | | City or Town, State, |) | | | | | | |
| COMPLETED | 29e. CERTIFIER (Check only (Ch | to death occurre | d at the time date | and place, and due | to the enverted and me | | 3 | | | | | |
| Σ | (Check only one) 2 MEDICAL EXAMINER: On the besis of examination are | | | | | | |) and manner on stated | | | | |
| | 296/Hannafull Sayon LE OF CENTURIER | 1 | | | | , | - | | | | | |
| BE | TANKE V | Merr | | 29c. LICENSE NUN | 7/1/ | 29d. DATI | SIGNED | (Modes Day Year) | | | | |
| ၉ | 30/ HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH | (ITEM 27) (Acco | Print) A | 1111 | 706 | | 0/3 | 417 | | | | |
| | STOOTHE METCHEN (MI) | 74. | Nov TH | en Au | = theor | Stew | IN. | (nd) | | | | |
| | AUG 3 0 1994 | Mandelly | | | | | | | | | | |

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notiffed at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



FOR STATE REGISTRAF

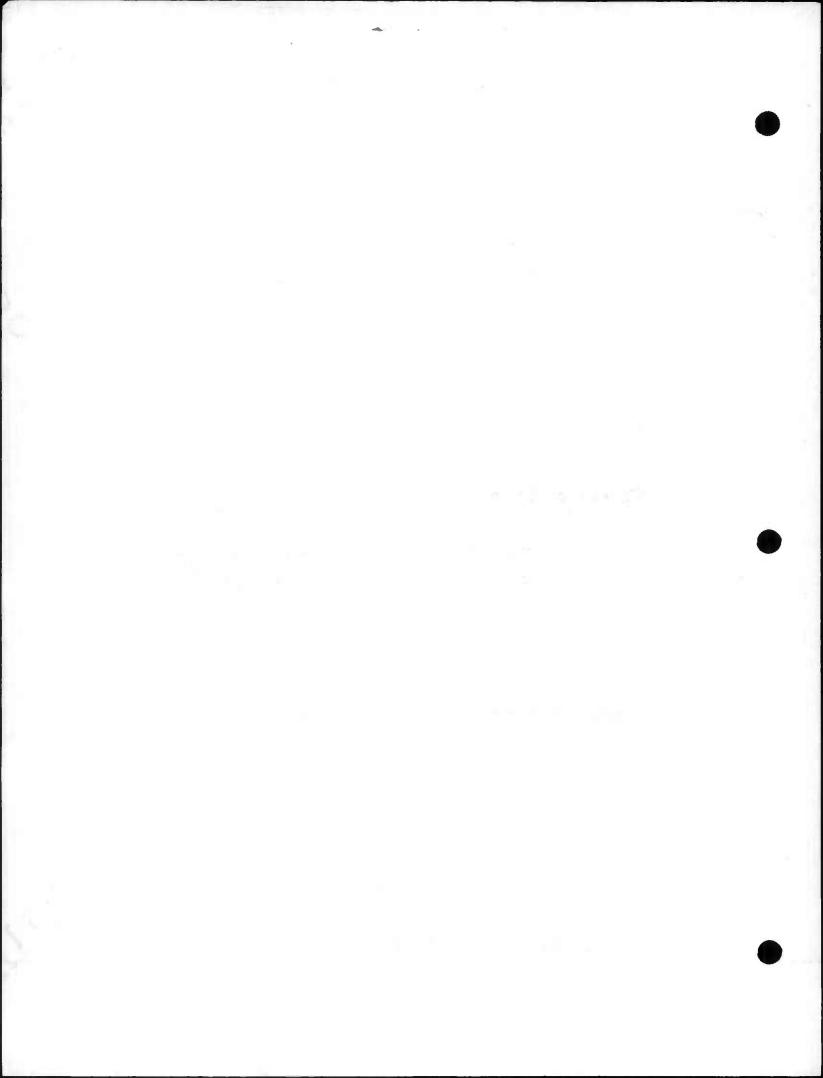
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

| | HEGISTHAR | | | ERITE | CALE | UF | DEA | 1 [| P | REG. NO. | | | | |
|--|--|---|------------------------------|----------------------|--|---|--------------|------------|-----------------|-----------------------------------|--------------|--------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | 10 L MG | | | | | | 2. DATE OF | | ¥ 1.0 | YEAR | 3. TIME OF DEATH | |
| | Dora Cather | | 10ATS | | | | | | Augus | st 19 | , 19 | 994 | 7:10 P M | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. | | IF UNDER | 1 YEAR | HOURS | 24 HRS. | 7. DATE OF I | BIRTH ly, Year) | | 8. BIRTI | HPLACE (State or Foreign | |
| | 218-50-0046 | 1 🗌 M 2 🙀 F | 60 | YRS. | MOINT IN | May 26, 1934 Wes | | | | | | Virginia | | |
| _ | 9a. FACILITY NAME (If not institution, give s | | | | 9b. CITY | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. | | | | | | c. COUNTY OF DEATH | | |
| DIRECTOR | Garrett County Me | morial H | ospital | L | Oakland | | | | | | Garrett | | | |
| ទ | RESIDENCE OF DECEDENT | | | | | OR LOCA | TION | | | | | | 10d. INSIDE CITY | |
| | MD | Garrett | | | | | TION . | | | | | | LIMITS? | |
| | 10e. STREET AND NUMBER | Garrett | 1 0. | akland 101. ZIP CODE | | | | | | 1 TYES 2 1 | | | | |
| FUNERAL | Star Rt. 2, Box | 21550 | | | | | | iog. Cri | | | | | | |
| 2 | 11. MARITAL STATUS | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify | | | | | acath. Voc | as Na | US. | A E — American Indian. | | | | |
| | 1 Never Married 2 Married | If yes, specify Cuban, Maxican, Puarlo Rican, atc.) | | | | | | Of 140— | Blac | k, White, atc. | | | | |
| BY | 3 Widowed 4 Divorced | | 1 □ YES 2 NO Specify: | | | | | | Spec | White | | | | |
| 3 | 15. DECEDENT'S EDU (Specify only highest grade | USUAL O | SUAL OCCUPATION 16b. KIND OF | | | | | INESS/IN | DUSTRY | | | | | |
| 4 | Elementary/Secondary (0-12) | College (1-4 or 5 + | | ife. Do NOT us | e retired.) | uunny mo | OST OF WORK! | ng | | | | | | |
| | 6th | | | Hou | swife | 2 | | | Н | ome | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOT | HER'S NA | ME (First, Midd | le, Maiden | Surname) | | | |
| | Adam | moats | | | | | A. | mand | a | | - | Во | fin | |
| | 19a. INFORMANT'S NAME (Type/Print) | | | 19b. MAILING | ADDRESS | (Street | and Number | or Rural F | Route Number, (| City or Tow | n, State, Zi | ip Code) | | |
| - | Delmar F. Moats | | | Star | Rt. | 2, | Box | 19, | Oaklan | d, M | aryl | and | 21550 | |
| | 20a. METHOD OF DISPOSITION 1 St Buriel 2 Cremetion 3 Rem | oval from State | | EAND DATE O | | | ame of | | DATE | | | City or To | | |
| | 4 Donation 5 Other (Specify) | | | rora (| Cemet | tery | | | 8/22 | Aur | ora, | Wes | t Virginia | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | | 22. | | NO ADDRE | | neral : | Home | | | | |
| | Brolley H. | Joursell | | | | 32 | S. S | Secon | nd St. | , 0a | klan | d, M | 21550 | |
| CERTIFICATION | 23. PART I. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Approximate interval Between Onset and Death Due to for As A consequence of: a. Hypo glyclmic Central Cent | | | | | | | | | | | | | |
| <u> </u> | resulting in death) LAST | | | | | | | | | | | | | |
| | PART ii Other algolficant condition | a contributing to | death but no | t regulting | in the un | ed a el ste | | elues la | Don't at | | | 1 | | |
| SAL S | The state of the s | a contributing to | Jean Dut 110 | t rasurting i | 2 The Street Court of the Court | | | | | 24a. WAS AN AUTOPSY PERFORMED? | | | AMILABLE PRIOR TO COMPLETION OF CAUSE | |
| ב ב | | | | | | | | | | YES 2 | M NO | | OF DEATH? | |
| Σ | DID TOBACCO USE | CONTRIBUT | TO CA | USE O | F DFA | TH | YES F | 7 NO | D 図 | | | | 1 NES 2 NO | |
| Z | 25. WAS CASE REFERRED TO MEDICAL | COLUMBOI | | .501 0 | | | - Las | | eck only one) | | | | | |
| PHYSICIAN | EXAMINER? 1 ☐ YES 2 🛣 NO | HOSPITAL: | ER/Outpatient | 3 🗆 004 | OTHER | R: | | | 6 Other (Sc | | | | | |
| É | 27. MANNER OF DEATH | 28a. DATE OF | NJURY | 26b. TIM | | _ | JURY AT | sidenca | 28d. DESCRI | | NJURY OC | CURED | | |
| | 1 Netural 5 Pending | (Month, De | y, Ybar) | INJ | URY M | WC | VES 2 | NO | | | | | | |
| 6 | 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE OF | INJURY At | home, term, s | street, fact | | | | 261. LOCATIO | ON (Street a | ind Numbe | or or Rural | Route Number. | |
| | 4 Homicide determined | building, | itc. (Specify) | | | | | | City or To | own, State) | | | | |
| 4 | 29a. CERTIFIER (Check only 1 💢 CERTIFYING PHYSI | CIAN: To the heat of | my knowledge | don'th again | el et the t | less detail | | | | | | | | |
| COMPLETED | (Check only one) 2 MEDICAL EXAMINE | | | | | | | | | | | | a) and manner as stated | |
| | 296. SIGNATURE AND TITLE OF SENTING | 9 | | 0 | | 17.7 | | ENSE NUN | | | | | | |
| | 11 | -oxec | no | n | 0 | | 104 | 241 | 1.4 | | zyd. DA | SIGNED | (Month, Day, Year) | |
| 2 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUS | E OF DEATH (IT | TEM 27) (Type. | Print) | | 11/1 | - / (| | | | 0/1 | 1/97 | |
| | Dr. Sotiere Savo | | | | | ami 1 | v Pr | acti | ce Cen | ter | Ter | ra A | / lta, WV26764 | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRA | 'S SIGNATURE | | | | , | | | , | 101 | _ ~ 11 | , 1120704 | |
| 31. DATE FILED (Month, Day, Year) 32. BEGISTRAR'S SIGNATURE AUG 2 4 1994 Julia Daudson-Radall | | | | | | | | | | | | | | |

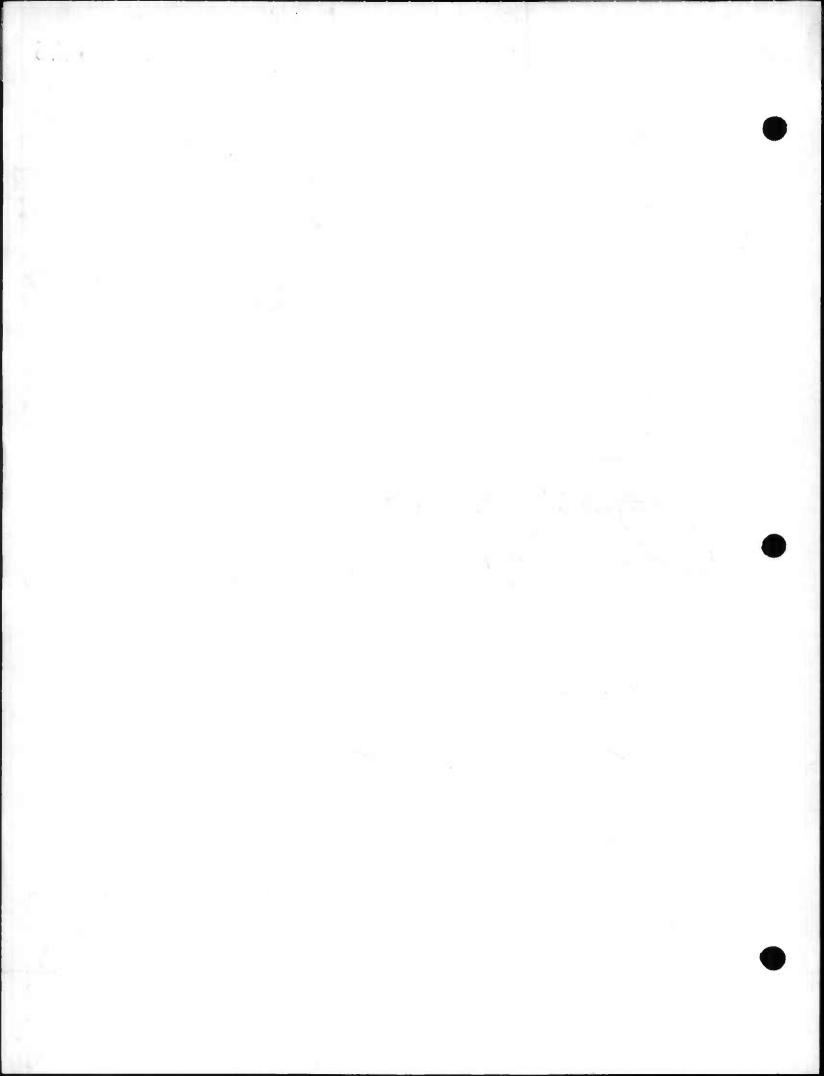
TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 2.4 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the befrial-that be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

DHMH-16 Rev 1/8

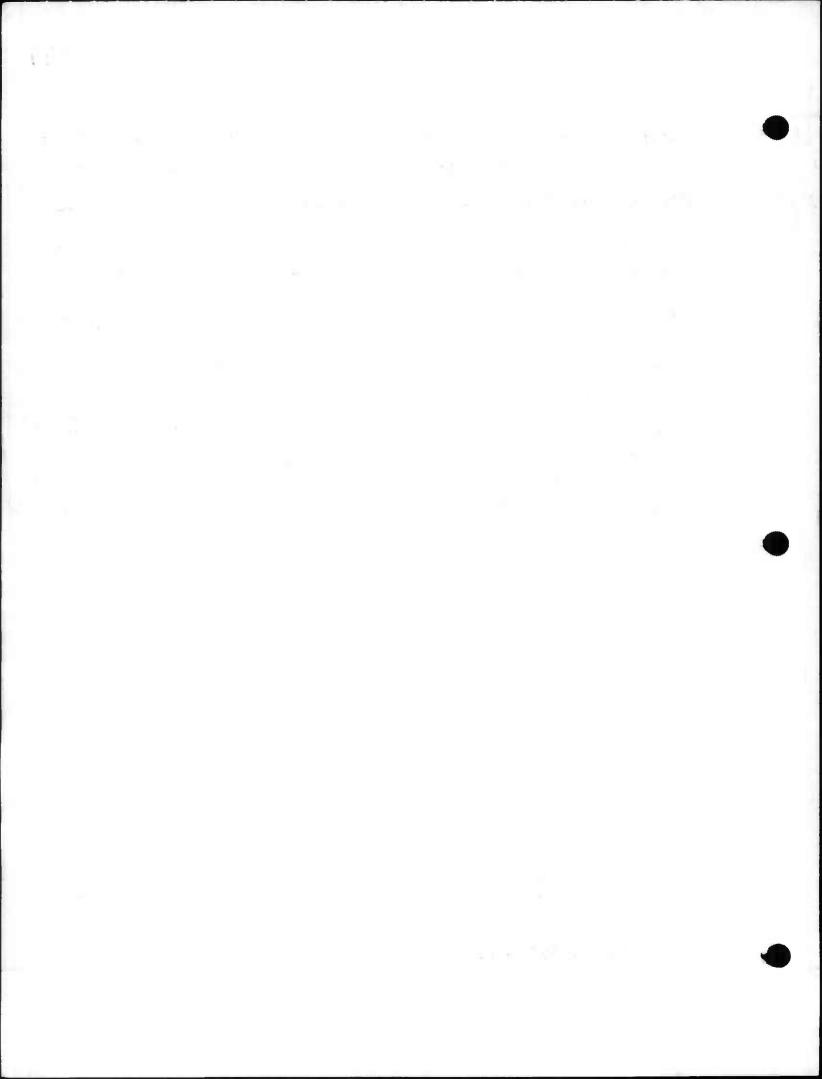


| | • | 1 - STATE REGISTRAR | STATE UF N | IAHYLA | OERTIF | | | | | IENT | AL HYGIEN REG. NO. | _ | | | |
|---------------|------|--|------------------------|---------------|---------------------------------|---------------------------|-------------|---------------|--------------|-------------|-----------------------|---------------|--|--|--|
| | 8 | 1. DECEDENT'S NAME (First, Middle, Last) GRACE M. | 11/1/2 /1 - | Y | | | | | | 2. DAT | TE OF DEATH | | YEAR | 3. TIME OF DEATH | |
| | 4 | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In | yrs. lest birthday) | IF UNDE | DAYS | IF UNDER | 24 HRS. | | E OF BIRTH | | 8. BIRTI- | IPLACE (State or Foreign | |
| | | 212-03-1201 | 1 M 2 F | 83 | YRS. | MONTHS | UMIS | nouns | | _1 | 1-15-1 | 910 | | YLAND | |
| Ι. | . | 9a. FACILITY NAME (If not institution, give | street and number) | | | 9b. CIT | Y, TOWN | OR LOCATI | ON OF DE | ATH | | 9c. COUN | ITY OF D | EATH | |
| 2 | 5 | S.P. MERIDIAN | NURSING | CEN | NTER | | SE | VERI | NA P | AR | K | AN | INE | ARUNDEL | |
| [| | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | CY. | | 10c CIT | Y. TOWN | OR LOCA | TON. | | | | | | 10d. INSIDE CITY | |
| DIDECTOR | 1 | | 100.01 | | | 1775 | | | | LIMITS? | | | | | |
| | | MARYIAND AND 100, STREET AND NUMBER | | SEV | | A P | | | | 1 TES XX NO | | | | | |
| FINEDAL | | IN. AIT COSE ING. CITEEN OF WINA | | | | | | | | | | | | | |
| 2 | | 11. MARITAL STATUS | 12. WAS DECEDENT | T EVED IN I | II S ADMED | 21146 | | | | | | | | | |
| | | 1 Never Married 2 Married | FORCES? 1 | YES | 2)(10 | | If yes, sp | ecify Cube | n, Mexican | , Puert | o Rican, etc.) | or No. | | E — American Indian, k, White, etc. | |
| > | | 3 🕅 Widowed 4 🗌 Divorced | IF TES, GIVE W | AH UH DAI | 23 | | 1 YES | XX | Specify: | | | | Spec | "Y: UCASIAN | |
| 6 | | 15. DECEDENT'S EDU | | | 16a. DECEDENT'S | | | | | 1 | 6b. KIND OF BUS | SINESS/IND | | OCASIAN | |
| L | | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 + |) | (Give kind of Itle. Do NOT u | work done se retired.) | during mo | st of working | ng | | | | | | |
| ē | | 12+ | | | H | OMEN | 1 A K E | R | | | | HOME | 2 | | |
| COMPLET | | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOT | HER'S NAM | E (Firs | t, Middle, Meiden | Sumame) | | | |
| R. | | VINCENT MURPHY | Y | | | | | | NEL | LI | E JONE | S | | | |
| E | | 19s. INFORMANT'S NAME (Type/Print) | | | 19b. MAILING | ADDRES | S (Street a | nd Number | or Aural A | oute Nu | imber, City or Tow | n, State, Zip | Code) | | |
| F | | MRS. NELL SING | GLETON | | 338 | FEF | RRY | POI | NT R | 0 A | D PASA | DENA | , M | ID 21122 | |
| | | 20a. METHOD OF DISPOSITION 1 ☐ Burlal 2 ☐xCremation 3 ☐ Rem | normal from Chata | | LACE AND DATE | | | me of | | D/ | ATE 20c. LO | CATION — | City or To | wn, Stata | |
| 1 | ľ | 4 Donation 5 Other (Specify) | _ | cemet | METRO | other place, C F | REMA | TOR | y 8 | +2 | 2-94 B | ALTI | TION — City or Town, State LTIMORE, MARYLA | | |
| 1 | I | 21. SIGNATURE OF FOREHAL SERVICE CO | CENSEE | | | 22. | NAME A | O ADORE | SS OF FAC | | | | | | |
| | - | Canca > | XD | 1 0 | ma & | | | | | | NS FUN | | | | |
| - | 7 | 20. PART I. Enter the diseases, or | complications the | caused t | the death Do | not enter | 1 9 5 | RIT | CHTE | H | WY SEV | ERNA | PA | | |
| (NOITE | 1 | Approximate interval Between Onset and Dasth Approximate interval Between Onset and Dasth Approximate interval Between Onset and Dasth Due to (of as a consequence of): Sequentielty list conditions, if any, leading to immediate cause. Enter UNDERLYING Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | | | |
| CERTIFICATION | | | | | | | | | | | | | | | |
| | | PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | | | | | | |
| CAL | | PERFORMED? AMALANE PRIOR TO COMPLETION OF CHIEF | | | | | | | | | | | | | |
| MED | | | | | | | | | | _ | 1 TYES 2 | KINO | | OF DEATH? | |
| 3 | | | | | | | _ | | | _ | | | | 1 NES 2 NO | |
| N N | | 25. WAS CASE REFERRED TO MEDICAL | | | | | 26. PI | ACE OF D | EATH (Che | ck only | one) | | | | |
| 1 8 | | EXAMINER? | HOSPITAL: | ER/Output | tient 3 🗆 DOA | OTHE | R: | | | | her (Specify) | | | | |
| PHYSICIAN | | 27. MANNER OF DEATH | 28s. DATE OF | INJURY | 28b. TIN | E OF | 28c. INJ | URY AT | - Politerior | | ESCRIBE HOW I | NJURY OCC | URED | | |
| | | 1 Netural 5 Pending | (Month, Da | try, Year) | IN. | JURY M | | RK7 YES 2 | NO | | | | | | |
| BY | | 2 Accident Investigation 3 Suicide 8 Could not be | 28e. PLACE O | F INJURY - | - At home, farm, | street, fac | tory, offic | • | | | DCATION (Street 1 | and Number | or Aural I | Route Number, | |
| 🖺 | 1 | 4 Homicide detarmined | building, | etc. (Specify | 7) | | | | | C | ty or Town, State) | | | | |
| ٣ | | 298. CERTIFIER 1 CERTIFYING PHYS | SICIAN: To the best of | mu knowle | dos deste occum | | time dete | and also | | | | 200 | | | |
| COMPLETED | | (Check only one) 2 MEDICAL EXAMINE | | | | | | | | | | | | and manner as stated | |
| | - 11 | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | - | | | | | | p.mod, at1 | | | | |
| 8 | | De Mar De | - MD. | | | | | | ENSE NUM | - | | | | (Month, Day, Year) | |
| 2 | 1 | 30. NAME AND ADDRESS OF PERSON WI | | E OF DEAT | H (ITEM 27) /5 | Defeat | | 1)1 | 5 Y . | | | // | UEV | 151 22,1914 | |
| 1 | | _ | | | | | h . | | | | | | _ | | |
| | - | JOSHUA IMPERA | 32. REGISTRA | TRS SIGNAT | TURE | nur | M | 103 | acus | ~ | ME : | 2112 | 1 | | |
| 1 | 10 | ATH "ソト TOO | | ALZ TITLE | A 1 48 | | | | | | | | | | |



| 3 | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | MENTAL | HYGIENE REG. NO. |
|---------------------------|---|-----------|---------------------|
| AME (First, Middle, Last) | | 2. DATE O | F DEATH |

| | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | MENTAL HYGIENE REG. NO. | | | | | | | | | |
|----------------------|--|--|--|--|--|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) MARTHA V. MOORER | 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH | | | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 578-32-2355 1 M 2 F | R 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign | | | | | | | | | |
| DIRECTOR | 98. FACILITY NAME (If not institution, give street and number) 99. CITY, TOWN OR LOCATION OF IT PRESIDENCE OF DECEDENT 99. CITY, TOWN OR LOCATION OF IT PRESIDENCE OF DECEDENT | | | | | | | | | | |
| | 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION OPENTON 10c. STREET AND NUMBER 10d. ZIP CODE | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | | | | | | | |
| FUNERAL | 1190 MONIERD 211 | 13 USA | | | | | | | | | |
| B | 11. MARITAL STATUS 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 3 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 2 Never Married 2 Never Married 1 Never Married 2 Nev | | | | | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4 or 5+) A SER VLE | 166. KIND OF BUSINESS/INDUSTRY | | | | | | | | | |
| BE CON | 17. FATHER'S NAME (First, Middle, Last) HTNRY ULSSCITER 18. MOTHER'S N | AME (First, Middle, Melden Surname) SALYN UNKNOWN | | | | | | | | | |
| 5 | 190. INFORMANT'S NAME (Type/Print) ANNE MOORER 190. MAILING ADDRESS (Street and Number or Rural 191. MAILING ADDRESS (Street and Number or Rural 190. MAILING ADDRESS (Street and Number or Rural | Route Number, City or Town, State, Zip Code) ECUAL ANNAPULS, MOGO | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION 1 | DATE 20c. LOCATION - City or Town, State 22-94 Cato Asulle, MO | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF R BARRAY GO | ACILITY SO TO TO AT HOME | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Approximata interval Between Onset and Death i Sk | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Consumy Antery Disease: | 1 Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | | | |
| ICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Mospiral 2 FR/Outpatient 3 DAG 4 Note No. 1 | | | | | | | | | | |
| BY PHYS | 1 YES 2 NO 1 Morting Home 5 Rasidence 27. MANNER OF DEATH 1 Netural 5 Pending (Month, Dey, Year) 28. DATE OF INJURY (Month, Dey, Year) 28. TIME OF INJURY AT WORK? 1 YES 2 NO | 6 Other (Specify) 26d. DESCRIBE HOW INJURY OCCURED | | | | | | | | | |
| | 3 Suicide 6 Could not be determined 28s. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) | 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFVING PHYSICIAN: To the best of my knowledge, dasth occurred at the filme, data and place, and duration one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the | a to the ceuse(a) and manner as stated. b time, data and piece, and dus to the cause(a) and manner as stated. | | | | | | | | | |
| H | 29b. SIGNATURE AND TITLE OF CERTIFIED 29c. LICENSE NU 29c. LICENSE NU 29c. LICENSE NU | 1 | | | | | | | | | |
| 6 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 8 SS PANA GON COUNT WARREN MARILLEON NO 2077 31. DATE FILED (Month, Day, Your) 32. REGISTRAR'S SIGNATURE | | | | | | | | | | |
| | 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE AUG 25 1994 Julia Dawelon Randall | | | | | | | | | | |



| 94 26240 | | 9 | 4 | | 4 | D | 6 | 4 | C |
|----------|--|---|---|--|---|---|---|---|---|
|----------|--|---|---|--|---|---|---|---|---|

REG. NO 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR Kenneth E. Nutter II8 27 94 3:50PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign (Month, Den Year) XX M 2 □ F 16 235-15-0508 Maryland 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Memorial Hospital Allegany Cumberland RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Keyser 1 YES 2 NO 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 308 Fountainhead Drive 26726 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Puerto Rican, stc.) 1 YES 2 X NO Specify: White tos. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ive kind of work done Do NOT use retired.) Student N/A 16. MOTHER'S NAME (First, Middle, Maiden Surname) Marsha K. Smith 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 Fountainhead Drive Keyser, WV 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Nutter Family Cemetery 8/30/94 Keyser, WV 22. NAME AND ADDRESS OF FACILITY Rotruck-Smith Funeral Home 85 S. Main Street Keyser, 23. PART I. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heert failure. List only one ceuse on each line. Approximate interval Between **Onset and Death** 20 hrs Self inflicted gun shot wound to the head PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES OF DEATH? 1 TYES 2 T NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO' 26. PLACE OF DEATH (Check only one) OTHER: YES 2 NO Inpellent 2 - ER/Outpetlent 3 - DOA 6 C Other (Specify) 4 - Nursing Home 5 - Reside 28a. DATE OF INJURY (Month, Day, Year) 8/26/94 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 7:30P M 1 Natural 5 Pending self inflicted gun shot wnd 1 YES 27 NO BY 2 Accident 28e. PLACE OF INJURY — At home, lerm, street, fectory, office building, atc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 308 Fountianhead Keyser W Va 4 Homicide home 1 _ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Dpty Med Ex D 09157 8/27/94 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Snow. M.D. Deputy Med Exam 124 W. third Street Cumberland. Jalia a and water Randall SEP 071994

the burial-transit

retained by the hospital or attending physician. 5 should be detached for use as the burial-tran BALTIMORE, MARYLAND 21215-0020 page 5 hours after death. Page 6 may be director, funeral (in by the filled completely BOX 68760 executed with and com HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be DIVISION OF VITAL RECORDS, P.O. attending

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L DIRECTOR: After the Dours after death v

TO THE HOSPITAL OF THE FUNERAL D DE filed within 72 ho

DHMH-16 Rev 1/89

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THE RESERVE THE PROPERTY OF TH

| TO BE COMPLETED BY FUNERA | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION |
|---|---|
| examiner must be notified at once. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| rai. | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| the funeral director, page 5 should be detached for use as the burial-transit p | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit, |
| er death. Page 6 may be retained by the hospital or attending physician. | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with |
| BALTIMORE, MARYLAND 21215-0020 | DIVISION OF VITAL RECORDS, P.O. BOX 68760, |

| | FOR 1 STATE | STATE OF | MARYLAND / DEP/ | | | | | MENTAL | HYGIENI | E | | |
|---|--|------------------------|---|------------------|-----------|--------------------|-------------|-------------------------|-------------------------------|---------------|------------------------|--|
| | REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) | | CERTI | FICAT | E OF | DEA | ТН | 2. DATE OF MONTH | DA | Y | YEAR 3 | . TIME OF DEATH |
| | Frances Louise 4. SOCIAL SECURITY NUMBER | Nelson 5. sex | 6. AGE (In yrs. last birthda | | | | | | st 2. | 1994 | | 1432 |
| | Control of the Contro | 1 M 2 G F | 6. AGE (in yrs. lest birthda | MONTHS | DAYS | IF UNDE | MIN. | 7. DATE OF (Month, I | | | 8. BIRTHPL Country) | ACE (State or Foreign |
| | 218-52-8364 9e. FACILITY NAME (If not institution, give | X | 82 THS | | | | | Novembe | er 28. | | | |
| α. | | | | | | OR LOCAT | | EATH | | | TY OF DEA | |
| ECTOR | St. Mary's Hosp | ital | | Le | onar | dtow: | n | | | St. | Mary | r's |
| H | 10e. STATE 10b. COUNT | Y | 10c, C | TTY, TOWN | OR LOCA | TION | | | | 10 | Od. INSIDE CITY | |
| E | Maryland St. | Mary's | Leon | ardt | own | | | | | 1 | LIMITS? | |
| 2 H | 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHA | | | | | | | | | | | AT COUNTRY? |
| FUNERAL | Box 221, Nelso | 206. | 50 | | | Unii | ted S | States | | | | |
| 3 | 11. MARITAL STATUS | NT EVER IN U.S. ARMED | 13. | WAS DE | CENDENT | OF HISPAI | NIC ORIGIN? | (Specify Yes | | 14. RACE - | - American Indian. | |
| BY F | 1 Never Married 2 Married 3 XWidowed 4 Divorced | | 1 YES 2 THO | | | ecity Cubi | | n, Puerto Ric | en, etc.) | | Black, V Specify: | White, etc. |
| | | | | | | | | | | | Whi | te |
| 윤 | 15. DECEDENT'S EDI (Specify only highest grad | CATION e completed) | 16a. DECEDENT (Give kind | of work done | during me | ON ost of worki | ng | 16b. K | IND OF BUS | INESS/INDU | ISTRY | |
| LET | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | use retired.) |) | | | | | | | |
| Once. | 12 | | Homema | ker | | | | | | | | |
| 5 3 | | | | | | 1100 | | ME (First, Mic | | | | |
| B B | Louis Wade Long | | 2.00.000 | | | _ | _ | arie V | | | | |
| 들은 | | | 10000 | | | | | Route Number | | | | |
| 9 | Louis A. Nelson | 4 | | | | | Road | | | | | ryland |
| must | 1 Buriel 2 Cremation 3 Rer 4 Donation 6 Other (Specify) | . 0 | cometery, contrastly of | Alovsius Leonard | | | | | | | - City or Town, Stata | |
| medical examiner must be notified at once. TO BE COM | 22. NAME AND ADDRESS OF FACILITY Brinsfield Funeral Home | | | | | | | | | | | |
| <u>e</u> | Edward N. Brinsfield, Jr. M00052 P.O. Box 279, Leonardtown, Maryland 20650 | | | | | | | | | | | nd 20650 |
| other traumatic event, the medic | 23. PART I. Enter the diseases, or complications that caused the desth. Do not siter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on asch line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) | | | | | | | | | | | Approximate interval Between Onset and Desti |
| 8 | OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| r other traumatic | Sequentially list conditions, if any, laading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| E 2 | CAUSE (Disease or Injury | C | | | | | | | | | | |
| | that initiated evants resulting in deeth) LAST | DUE TO | O (OR AS A CONSEQUENCE | OF): | | | | | | | | |
| 9 1 111 | | d | | | | | | | | | | |
| any injur | PART II. Other eignificant condition | ns contributing t | o deeth but not resultin | g in the u | nderiyin | g ceuse | givan in | | PERFOR | MED? | AN CO | TERE AUTOPSY FINDINGS WAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? |
| 2 ≥ | | | | | | | | _ | | | 1 | YES 2 NO |
| N A | 25. WAS CASE REFERRED TO MEDICAL | | | | 20 D | ACE OF I | EATH /CA | ant ant and | | | | |
| SICI | EXAMINER? | HOSPITAL: | | OTHE | R: | | | eck only one) | | | | |
| 5 2 | 27. MANNER OF DEATH | 28e. DATE O | ER/Outpatient 3 DOA | IME OF | _ | JURY AT | esidenca | 6 Other (| Specify) | I II IBY OCCI | IDEA | |
| | 1 Natural 5 Pending | | | NJURY | W | YES 2 | □ NO | 200. 0200 | THE TION I | 100117 0000 | DILLO | |
| 8 U | Accident investigation Could not be determined A Homicide A Homicide A A A A A A A A A | 28e. PLACE building | OF INJURY — At home, terr j, etc. (Specify) | n, street, fac | | | | 28t, LOCAT City or | ION (Street a Town, State) | nd Number o | or Rural Rou | ite Number, |
| E W | 29a, CERTIFIER | | | | | | _ | | | | | |
| = 5 | (Check only | | of my knowledge, death occ examination and/or investig | | | | | | | | | nd manner as stated. |
| S | / | | | | | | | | | | | |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. BEGISTRAR'S SIGNATURE
Julia Davidson Rardall

William D. Boyd II, M.D.
31. DATE FILEO (Month, Day, Year) 32. DEGISTRA

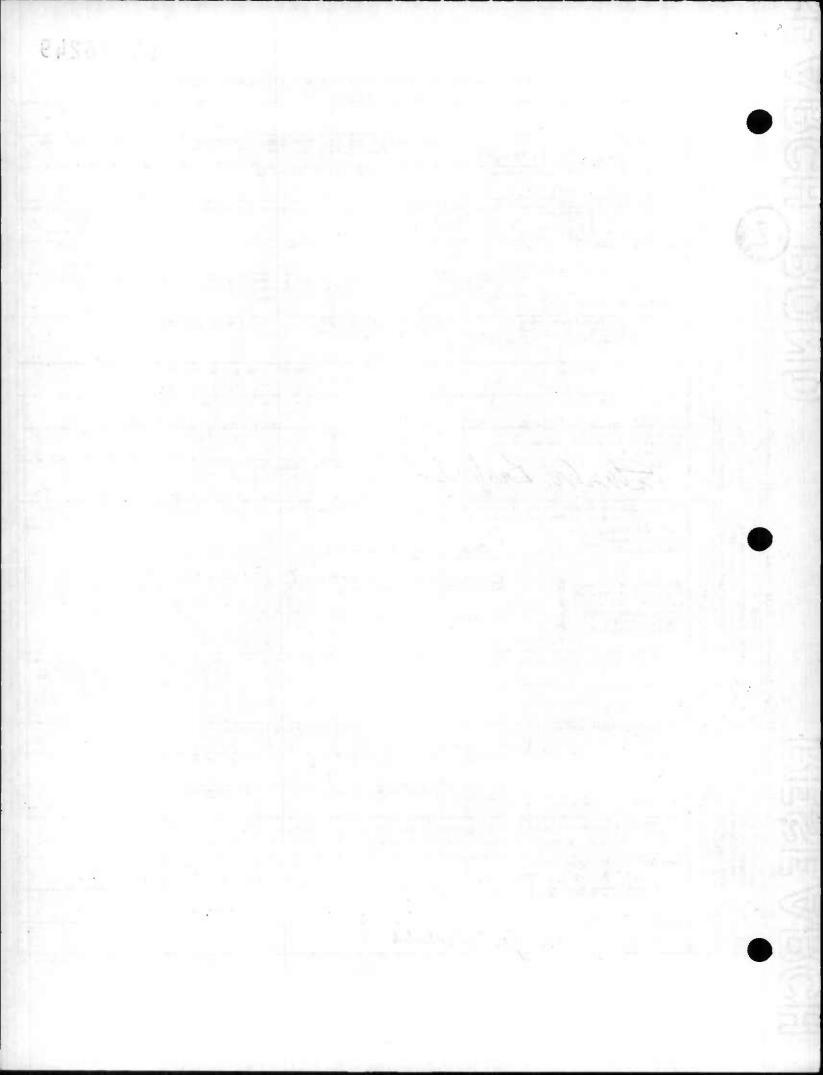
AUG n4 1994

DHMH-16 Rev 1/89

18-3-94

14285

17 Jefferson Street, Leonardtown, Maryland 20650



| THE PERSON NAMED AND PERSON | O DE COMBILETED DV DUVOIOIANI, MEDIOAL OFFICEIOATION |
|--|--|
| il examiner must be notified at once. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| NA. | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or minimal |
| the furneral director, page 5 should be detached for use as the burial-classif | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the three directors and the personnel of |
| in death. Page 6 may be retained by the hospital or attending physician. | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a cours after death. Page 6 may be retained by the husbillal or arranging physician. |
| BALTIMORE, MARYLAND 21215-0020 | DIVISION OF VITAL RECORDS, P.O. BOX 68760, |
| - | |

| | 1 - STATE REGISTRAR | STATE OF MARYL | | | F HEALTH AND | | YGIENE EG. NO. | | | | | |
|---------------|--|---|-------------------------|------------------------|---|---|-----------------------|-----------------------------|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF D | EATH | | | 3. TIME OF DEATH | | |
| | Reynaldo | | Ocfem | ia | | Aug 18 | , 19 | | YEAR | 1:22 P M | | |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. last birthday) | IF UNDER 1 YE | | 7. DATE OF B | IRTH Weet | | Countr | PLACE (State or Foreign | | |
| | 576-38-0343 | 1 X M 2 □ F 69 | YRS. | | | Jul 24 | , 192 | 25 | Ph: | lippine | | |
| œ | 90. FACILITY NAME (If not institution, give s Naval Hospital | :treet and number) | | | WN OR LOCATION OF D | EATH | | 9c. COUN | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT | | | Patux | ent River | | | St. Mary's | | | | |
| E I | 10a. STATE 10b. COUNT | | | Y, TOWN OR L | | | | 10d. INSIDE CITY LIMITS? | | | | |
| | Maryland St. M | ary's | Lex | kingto | | | | 1 YES 2 X NO | | | | |
| IEBAI | 100. STREET AND NUMBER 65 Hillside Drive | | | 101, ZIP CODE 20653 | | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 🔀 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER I FORCES? 1 X YES IF YES, GIVE WAR OR D | 2 NO | II yes | DECENDENT OF HISPA I, specify Cuban, Mexic YES 2 NO Speci | an, Puerto Rican | | or No — | - American Indian, t, White, etc. dy: ayan | | | |
| 8 | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 18a. DECEDENT'S | USUAL OCCUP | PATION g most of working | 16b. KINI | D OF BUSI | NESS/IND(| | ayan | | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT us | e retired.) | • | | | | | | | |
| M P | 12th grade | | Girei | SIITDSE | rviceman | | S. N | | | | | |
| BE CC | | Ocfemia | | | Silveri | AME (First, Middle .a | , Maiden S | Vill | area | al | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) Margaret Bell Ocfe | emia | 65 Hi | ADDRESS (Str Llside | oet and Number or Rural Dr., Lexi | Route Number, C. .ngton 1 | ity or Town, Park, | State, Zip | ^{Code)} 206 | 553 | | |
| | 20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Rem 4 Denation 5 Other (Specify) | loval from State | b. PLACE AND DATE O | PEDISPOSITION | N(Name of | 3/94 | | nata | - | | | |
| | | | | | | | | | | | | |
| CERTIFICATION | 23. PART L. Inter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Due To (OR AS A CONSEQUENCE OF): B. Due To (OR AS A CONSEQUENCE OF): Due To (OR AS A CONSEQUENCE OF): Due To (OR AS A CONSEQUENCE OF): Due To (OR AS A CONSEQUENCE OF): Due To (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| AL CER | PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a, WAS AN AUTOPSY FINDINGS | | | | | | | | | | | |
| MEDIC | | | | | | 1 | YES 2 | | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| | DID TOBACCO USE C | ONTRIBUTE TO | CAUSE OF | DEATH | YES NO | X | | | | | | |
| 3 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 1. | OTHER: | B. PLACE OF DEATH (CA | ck only one) | | | | | | |
| HYSICIAN: | 1 YES 2 NO 27. MANNER OF DEATH | 1 Inpatient 2 ER/Out | _ | 4 - Nursing | Home 5 🗆 Residence | 8 Other (Spe | ecify) | | | | | |
| <u>-</u> | 1 Natural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIMI INJ | URY | WORK? | 28d. DESCRIB | E HOW IN | JURY OCC | URED | | | |
| TED B | Accident Investigation Suicide 6 Could not be determined | 28e. PLACE OF INJURY building, etc. (Spe | Y — At home, larm, a | treel, lactory, | office | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| P.E. | 29a. CERTIFIER (Check only | ICIAN: To the beat of my know | viedge, death occurre | d at the time, | date and place, and du | to the cause(s) | end mann | er as state | d. | | | |
| COMPLE | | ER: On the basis of examination | | | | | | | |) and manner as stated. | | |
| BEC | 296. SIGNATURE AND TITLE OF CERTIFIE | " 1 | | | 29c. LICENSE NU | MBER | | 29d. DATE | SIGNED | (Month, Day, Year) | | |
| 0 | mel | Armo | | | 1718 | 285 | | 1 | 11 | 9/94. | | |
| | 30. NAME AND ADDRESS OF PERSON WHO William D. Boyd, | | EATH (ITEM 27) (Type, | | rdtown, Ma | rvland | 206 | 550 | | | | |
| į | 31 DATE Ell ED (Month Day Year) | 22 DECISTRADIO CICA | ATURE O | | | | | | | | | |
| | AUG 22 19 | 194 Juli Dav | when travelal | Ç. | | | | | | | | |

mit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Jours after death. Page 6 may be retained by the hospital or in the TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

| | | | | | | OI DE | AIIII | | HEG. NO. | | | |
|--------------|---|-------------------------------|---------------------|---------------------|---|--------------------------|---------------|---|--|-------------------|-------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) THOMAS | SUMNER | | OLIVI | gr _D | | | M | NATE OF DEATH | | YEAR | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | | 8. AGE (In yrs. las | | IF UNDER 1 Y | | | + | | 9,19 | | 6:20 A M |
| | 521-07-9664 | 1 M 2 F | 92 | YRS. | | AYS HOU | IDER 24 HRS. | AU | GUST 26, | 1000 | PEN | PLACE (State or Foreign NSYLVANIA |
| | 9a. FACILITY NAME (If not institution, give str | reet and number) | · · · · · · | | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEA | | | | | | EATH | |
| TOR | FRIENDS NURSING | | SANDY SPRING MONTO | | | | | | ONTGO | MERY | | |
| <u>입</u> | 10a, STATE 10b, COUNTY | I too CITY | Y, TOWN OR | OCATION | | | | | | 444 1110100 01714 | | |
| DIRECTOR | MONTO | | NDY S | | | | | 10d. INSIDE CITY LIMITS? 1 □ YES 2 🗺 NO | | | | |
| IAL | 17320 QUAKER LA | | | 10f. ZIP (| | | | 10g. CITIZEN OF WHAT COUNTRY? | | | | |
| FUNERAL | <u> </u> | | | | | | | 086 | | | ITED | STATES |
| 尼 | 11. MARITAL STATUS 1 Never Merried 2 Married | 12. WAS DECEDENT FORCES? 1 | | | 13. WA | B DECENDE | IT OF HISPA | NIC OF | RIGIN? (Specify Yea erto Rican, etc.) | or No- | 14. RACI Bloc | E — American Indien, k, White, atc. |
| ED BY | 3 Wildowed 4 Divorced | IF YES, GIVE WA | R OR DATES | | | YES 2 | | | | | Spec | " WHITE |
| ED | 15. DECEDENT'S EDUC (Specify only highest grade of | | (G | ive kind of w | USUAL OCCU | IPATION ing most of w | orking | | 16b. KIND OF BUS | INESS/IN | OUSTRY | |
| COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | | DO NOT US ISULT. | ANT EI | VGINE | ER | | ELECTRI | CAL | ENGI | NEERING |
| NO. | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | | irst, Middle, Malden | Surneme) | | |
| BE (| | IVER | | | | | BERTH | | HANEY | | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) RUTH TANGUY O | LIVER | 196 | | ME AS | | nber or Rural | Route | Number, City or Town | n, State, Zi | p Code) | |
| | 20a. METHOD OF DISPOSITION 1 | oval from State | 20b. PLACE | AND DATE O | F DISPOSITION C | N (Name of REMAT | ORY | | | | ORIA, | ven, State VIRGINIA |
| | 21. SIGNATURE OF FUNERAL SERVICE LIGH | EMBEE | 1 | | 23 MU | CIEL AD | HESS OF A | RBE | R FUNERA | L HO | OME | 20882 |
| | Murief XI - | Bar | her | | P.O.BOX 5038 LAYTONSVILLE, MD. | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such ea cerdlec or respiratory errest, shock, or heart fellure. Liet only one cause on each line. Approximate interval Between | | | | | | | | | | | |
| | IMMEDIATE CALICE (Fine) | | | | | | | | | | | |
| i | disease or condition a. ASHD E Suprementricular arrhythma years DUE TO (OR AS A CONSEQUENCE DE): Multi-infanct dementia | | | | | | | | | | | |
| NO | Sequentially list conditions, OHE TO (NR AS A CONSEQUENCE OF) | | | | | | | | | | | |
| CAT | If any, leading to immediate cause. Enter UNDERLYING | | | | | | | years | | | | |
| Ĕ | CAUSE (Disease or Injury that initiated events | EOUENCE OF): | | | | | | | | 1000 | | |
| HH | resulting in death) LAST | | | | | | | | | | | |
| | | | | | | | | I. 24a. WAS AN . PERFOR | | 246 | . WERE AUTOPSY FINDINGS | |
| EDICAL | | | | | | | | | | / | | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| | | | | | | | | | | 1 YES 2 40 | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | - | | | 20 DI ACE (| F DEATH (C | back co | 1 | | | |
| SICI | EXAMINER? 1 VES 2 NO | HOSPITAL: | ER/Outpetlent 3 | □ DOA | OTHER: | | 1974 | | Other (Specify) | | | |
| PHYSICIAN: M | 27. MANNER OF DEATH | 28e. DATE OF I (Month, Day | NJURY r, Ybar) | 28b. TIM | | c. INJURY A | | 7 | OESCRIBE HOW IN | JURY OC | CURED | |
| à l | 1 Maturel 5 Pending 2 Accident Investigation | 28e PLACE OF | INJURY — At ho | me form a | | | 2 NO | 200 | LOCATION (Observed | and Moranha | | |
| COMPLETED | 3 Suicide 8 Could not be determined | building, e | tc. (Specify) | , rem, e | nreet, tactory | Office | | 281. | LOCATION (Street a City or Town, State) | na Numbe | or Humil i | Houte Number, |
| PP. | 29a. CERTIFIER (Check only one) | | | | | | | | | | | |
| 00 | MEDICAL EXAMINER | | mination and/or | Investigatio | n, in my opin | ion, death o | ccured et th | e time, | data and place, and | d due to t | he cause(i | s) and manner as stated. |
| BE | 296 SIGNATURE AND TITLE OF CERTIFIED | Curlo | MD | | | 29c. | LICENSE NU | MBER | | 29d. DA | ZA S | (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | | OF DEATH (ITE | M 27) (Type, | Print) | ٨ | | IV. | | | + + | |
| | 31. DATE FILED-(Aponta Day, Year) 100 | 32. REGISTRAN | 17704 | Ge | orgia - | toe | Ola | ex | MD 20 | 837 | | |
| | SEP 0 2 1994 | | | | | | | | | | | |

| 1 | | FOR STATE REGISTR |
|---|------|-------------------------|
| : | 1. 1 | DECEDENT'S |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCICUS

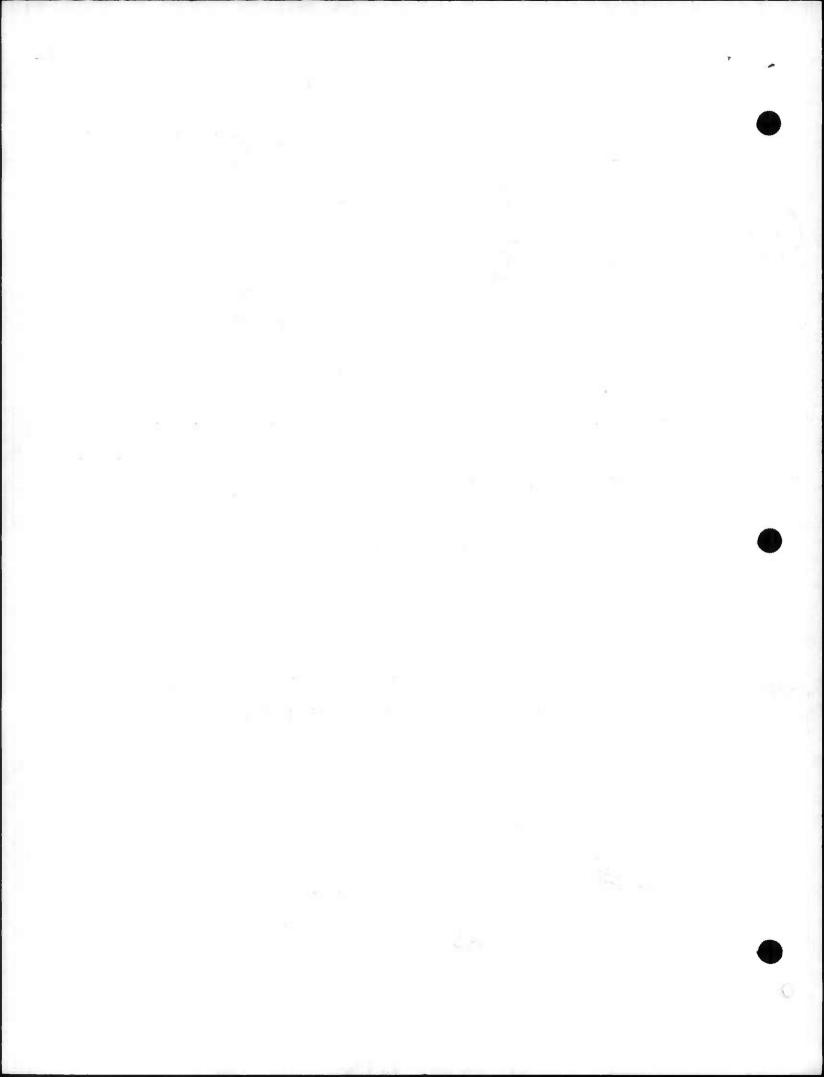
| | 1 - STATE REGISTRAR | C | | | | DEATH | REG. | | | | | | |
|---------------|--|---|---|----------------|-----------------|------------------------------------|---|---------------|---------------|---|--|--|--|
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH | | | | | | | | | | | | |
| - 1) | William Albert Palmer | | | | | | | Aug. 25, 1994 | | 2:35 A M | | | |
| Į. | 4. SOCIAL SECURITY NUMBER 5. SEX | 6. AGE (In yrs. I | yrs. lest birthday) IF UNDER 1 YEAR | | | IF UNDER 24 HRS. | 7. DATE OF BIRTH 8. | | S. BIRTH | IPLACE (State or Foreign | | | |
| | 212-10-8063 1XM 2 | □ | YRS. | MONTHS | DAYS | HOURS MIN. | Dec 5. | 1898 | M a | ryland | | | |
| | 9a. FACILITY NAME (If not institution, give street and num | ber) | _ | 9b. CITY, | TOWN O | R LOCATION OF D | | | | | | | |
| DIRECTOR | Meridian Nursing Home Baltimore City | | | | | | | | | | | | |
| EC | 10a. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN OF | LOCAT | ION | | | | 10d, INSIDE CITY | | | |
| PIG | Maryland Baltim | ore | Sparks | | | | | | | LIMITS? | | | |
| | 10e. STREET AND NUMBER | | | 10f. | ZIP CODE | | | | WHAT COUNTRY? | | | | |
| BY FUNERAL | 2119 Stringtown Ro | | | | 2115 | | | | SA | | | | |
| | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 X Wildowed 4 Divorced 12. WAS DE FORCE: IF YES, | CEDENT EVER IN U.S. A S? 1 YES 2) GIVE WAR OR DATES | 13. WAS DECENDE 2 ATES 13. WAS DECENDE If yes, specify 1 YES 2 X | | | cify Cuban, Maxic | DENT OF HISPANIC ORIGIN? (Specify Yes or No— fry Cuban, Maxican, Puerto Rican, etc.) NO Specify: | | | E — American Indian, k, White, atc. #/y: White | | | |
| ED | 15. OECEDENT'S EDUCATION (Specify only highest grade completed) | ECEDENT'S | | | | 16b. KIND OF BUSINESS/INOUST | | | | | | | |
| | Elementary/Secondary (0-12) College (1- | 4 or 5+) | Give kind of work done during most of working le. Do NOT use retired.) | | | | | | | | | | |
| MPI | 8 | | Carp | enter | r | | | MTA | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | AME (First, Middle, M | |) | | | | |
| BE | | Hiram V. Palmer Lydia Shafer | | | | | | | | | | | |
| 5 | 190. INFORMANT'S NAME (Type/Print) George V. Palmer | | | | | | Sparks | | | 52 | | | |
| | 20a. METHOD OF DISPOSITION XLXBurlal 2 Cremation 3 Ramoval from St | | AND DATE | | | · - · · · | | c. LOCATION - | | | | | |
| d | XCXBurial 2 Cremation 3 Ramoval from St 4 Donation 5 Other (Specify) | ete cemetery c | | | | | d 8/27 | Timon | ium. | Md. | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 111 - | 1 | | | D ADDRESS OF FA | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Eline Funeral Home 934 S Main St, Hampstead, Md 21074 | | | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complication | na thet caused the d | leeth. Do r | not enter t | tha mo | de of dying, suc | ch as cerdiac or | respiratory a | rreat, | Approximate | | | |
| | shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death | | | | | | | | | | | | |
| | MMEDIATE CAUSE (Final disease or condition resulting in deeth) a. Kenal Failure | | | | | | | | | | | | |
| _ | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate | DUE TO (OR AS A CONS | EQUENCE O | F): | | | | | | | | | |
| S | CAUSE (Disease or Injury | | | | | | | | | | | | |
| | that initiated evente reaulting in deeth) LAST | DUE TO (OR AS A CONS | EOUENCE O | F): | | | | | | | | | |
| 띩 | d | | | | | | | | | | | | |
| 7 | PART II. Other significent conditione contribut | | | | | | Part I. 24a, W | S AN AUTOPS | y 24t | a. WERE AUTOPSY FINDINGS | | | |
| MEDICAL | ASCUD, Coron | ary h | conf | de | se | me - | | RFORMED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | |
| 빌 | | | | | | | | | | OF DEATH? | | | |
| ž | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO | | | | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | _ | ACE OF DEATH (C | heck only one) | | | | | | |
| SIC | | nt 2 ER/Outpetient | 3 DOA | OTHER Nursi | | e 5 🗆 Rasidenca | 6 Other (Specif) | 1) | | | | | |
| E | | ATE OF INJURY forth, Day, Year) | 26b, TIM | IE OF | 28c. INJI WO | URY AT RK? | 28d. DESCRIBE | IOW INJURY O | CCURED | | | | |
| В | 1 Natural 5 Pending 2 Accident Investigation | | | М | 1 🔲 Y | ES 2 NO | | | | | | | |
| 8 | 3 Suicide 8 Could not be 4 Homicide detarmined | ry, offici | ffica 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 9 | 29a. CERTIFIER | | .61. | | | (top // | | V | | | | | |
| COMPLET | (Check only one) 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the be | | | | | | | | | s) and menner as stated. | | | |
| | 29b. SIGNATURE AND THE SECTION OF | | 29c. LICENSE NU | | | 29d. DATE SIGNED (Month Day, Year) | | | | | | | |
| D 53 | | | | | | | 99d. DATE : | | 8/2 | 6/96 | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETE | D CAUSE OF DEATH (IT | EM 27) (Type | Print) | | | | | 1 | 7-1 | | | |
| | Dr Vissin 4 | Dr Vissin 4300 N. Charles St Towson | | | | | | | | | | | |
| | 11 0 11 11 | GISTRAR'S SIGNATURE | | | | | | | | | | | |

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within thous after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burital-transbe filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

OHMH-16 Rev 1/89

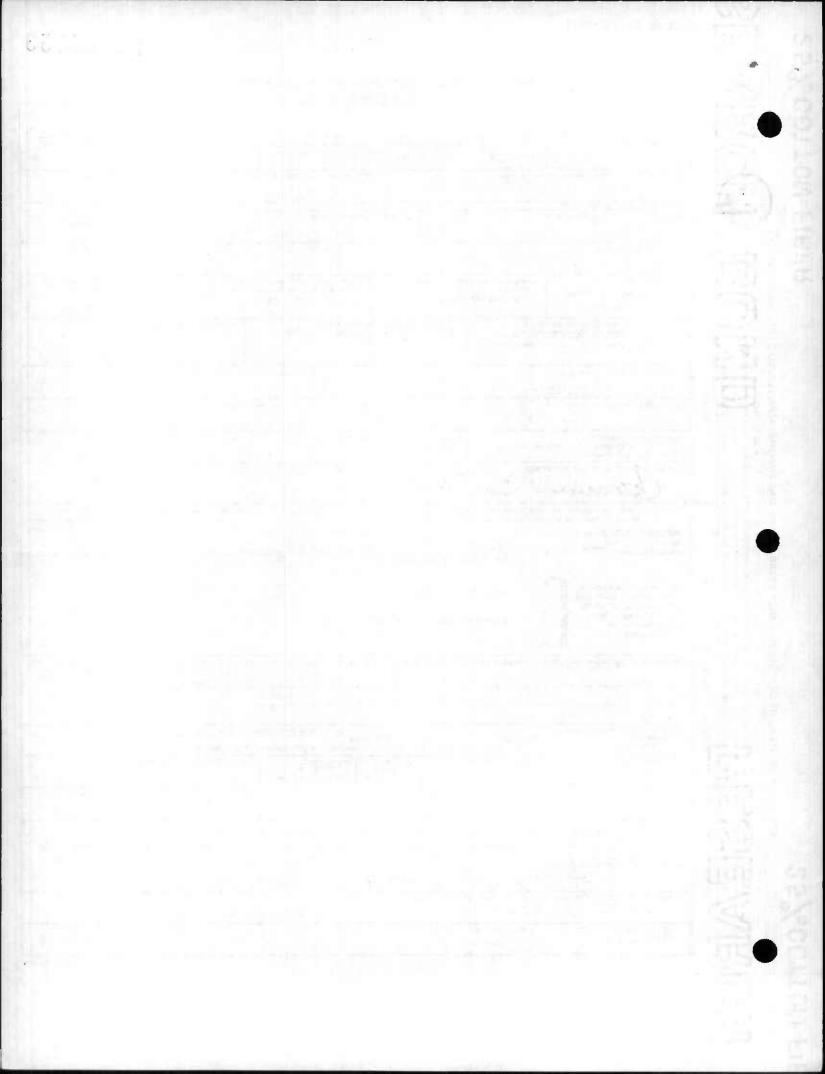


| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | BALTIMORE, MARYLAND 21215-0020 |
|---|--|
| TO THE HOSPITAL DA ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. From start death. Page 6 may be retained by the hospital or attending physician. | after death. Page 6 may be retained by the hospital or attending physician. |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit is be find within 72 hours after death with the State Deor, of Health and Mental Hydiene prior to burial, cremation, or removal. | by the funeral director, page 5 should be detached for use as the burial-transit; moval. |
| IMPORTANT, If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | ical examiner must be notified at once. |

31. DATE FILED (Mopth, Day, Year)

32. REGISTRAR'S SIGNATURE

| |) | | | | 2. DATE OF DEATN | | 3. TIME OF DEATN | | | |
|--|---|---|---------------------------------|------------------------|--|---------------------|---|--|--|--|
| William Th | omas Pa | rrv | | | MONTH [| 2 94 | RA | | | |
| 4. SOCIAL SECURITY NUMBER | | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BURTN | 8. E | SIRTHPLACE (State or Foreign | | | |
| 220-20-1862 | 1 📉 M 2 🗆 F | 67 YRS. | ONTHS DAYS | HOURS MIN. | | ug.4, 1927 Maryla | | | | |
| 9e. FACILITY NAME (If not institution, give | atreet and number) | | | R LOCATION OF DEA | тн | 9c. COUNTY | OF DEATH | | | |
| 125 Main St. | | | New | Windsor | | Ca | rroll | | | |
| 10a. STATE 10b. COUN | TY | 10c. CITY, | TOWN OR LOCATI | ON | | | 10d. INSIDE CITY | | | |
| Maryland Car | roll_ | | New W | indsor | | | 1 X YES 2 NO | | | |
| 10e. STREET AND NUMBER | | | 10f. | ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? | | | |
| 125 Main St. | | | | 21776 | | U.S | S.A. | | | |
| 11. MARITAL STATUS 1 Never Married 2 Married | FORCES? 1 | EVER IN U.S. ARMED VES 2 NO | | ENDENT OF HISPANIC | C ORIGIN? (Specify Ye Puarto Rican, etc.) | e or No- 14. | RACE — American Indian, Black, White, etc. | | | |
| 3 Widowed 4 Divorced | 1946-48 | | | 2 X NO Specify: | • | | Specify: | | | |
| 15. DECEDENT'S ED | UCATION | 16a. DECEDENT'S U | SUAL OCCUPATION | N | 16h KIND OF BI | JSINESS/INDUST | White | | | |
| (Specify only highest green (S | College (1-4 or 5 +) | (Give kind of wo | rk done during mos retired.) | l of working | | | | | | |
| 12 | | forema | n | | quarr | y/cemen | it co. | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 16. MOTNER'S NAM | E (First, Middle, Maider | | | | | |
| Clifford Henry P. | arry, Sr. | | | Rose N | Marie Fra | nklin | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILINO A | DDRESS (Street an | nd Number or Rural Ro | oute Number, City or Tox | wn, Stete, Zip Cod | (o) | | | |
| Jeffrey F. Parry | | 125 Mai | n_St. | New Wind | dsor, MD | | | | | |
| 20a. METHOD OF DISPOSITION 1 \(\tilde{\Omega} \) Burial 2 \(\tilde{\Omega} \) Cremation 3 \(\tilde{\Omega} \) Re | moval from State | 20b. PLACE AND DATE OF cemetery, crematory or other | DISPOSITION (Name of place) | | DATE 20c. L | | | | | |
| 4 Donation 6 Other (Specify) 21. SIGNATUMB OF FUNERAL SERVICE L | 7 | Pipe Cre | ek Cemet | ery | 8/25 nr | . New W | indsor, MD | | | |
| atharine | V. Xar | Dler | | w Windson | р.р. н | artzler | & Sons | | | |
| New Windsor, MD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | |
| IMMEDIATE CAUSE (Final | . List only one cous | e on each line. | | | | | Onset and Das | | | |
| disease or condition resulting in death) | Sq. C | ell Carcinon | a, Floo | r of Mou | th | | 9/92 | | | |
| | DUE TO (O | OR AS A CONSEQUENCE OF): | | | | | 3,732 | | | |
| Sequentially list conditions | b | | | | | | | | | |
| Sequentially liet conditions, if any, leading to immediate | DUE TO (O | OR AS A CONSEQUENCE OF): | | | | | | | | |
| cause. Enter UNDERLYING CAUSE (Disease or Injury | c | OR AS A CONSEQUENCE OF): | | | | | | | | |
| that initiated events resulting in death) LAST | 0) 01 300 | M AS A CONSEQUENCE OF): | | | | | | | | |
| | d | | | | | | | | | |
| PART II. Other significent condition | one contributing to d | eath but not resulting in | the underlying | cause given in P | | N AUTOPSY PRMED? | 24b. WERE AUTOPSY FINDING | | | |
| Metastasis t | o Neck | | | | 1 _ YES | | COMPLETION OF CAUSE DF DEATH? | | | |
| | | | | 10.1 | _ | | 1 TES 2 NO | | | |
| | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 26. PL | ACE OF DEATH (Chec | k only one) | | | | | |
| 1 TYES 2 NO | | ER/Outpatient 3 DOA 4 | ☐ Nursing Home | 5 X Residence 6 | | | | | | |
| 27. MANNER OF DEATN 1 Netural 6 Pending | 26a. DATE OF IN (Month, Day, | (JURY 26b. TIME INJUI | TY WOF | PK? | 26d. DESCRIBE NOW | INJURY OCCURE | ED . | | | |
| 2 Accident investigation | 100000000000000000000000000000000000000 | | | E\$ 2 NO | | | | | | |
| 28e PLACE OF IN HIRV At home from street festory office | | | | | | | | | | |
| 3 Suicide 4 Nomicide 4 Nomicide 5 Could not be detarmined 29e. CERTIFIER (Check only 1 CERTIFYINO PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. | | | | | | | | | | |
| 200. CERTIFIER X | SICIAN: To the heet of m | y knowledge, death occurred | at the time, date | and place, and due to | o the cause(a) and ma | enner as stated. | | | | |
| a mark | | | | | and the same of th | | | | | |
| (Check only | NER: On the beels of axe | | | eath occured at the ti | me, data and place, a | and dua to the ca | use(a) and manner as stated. | | | |



DIVISION OF VITAL RECORDS. P.O. BOX 68760.

| | Velma | Wesse | 770 | | Pen | n ė we: | 1 1 | | | 2. DATE | OF DEATH | AY | YEAR | 3. TIME OF DEATH |
|------------------------------------|---|--|---|---|--|---|--------------------------------------|--|--|--|---|--|------------|---|
| | 4. SOCIAL SECURITY NUMBER | 5. Si | | 6. AGE (In v | yrs. lest birtho | | R 1 YEAR | IE IIMDE | R 24 HRS. | - | OF BIRTN | | a DIOTA | IPLACE (State or Fore |
| | 230-42-5144 | | M 2 💢 F | 85 | YR | S. MONTHS | DAYS | HOURS | MINE. | (Mont | 14/09 | | Counti | y Virginia |
| oc | 9a. FACILITY NAME (If not institution | n, giv e street ar | nd number) | | | Pocomoke, Md. | | | | | | | | |
| DIRECTOR | 7 Front St. | NT | _ | | | | Poco | moke | , Md | • | Worcester | | | |
| E | | COUNTY | | | 10c. | CITY, TOWN | OR LOC | ATION | | | 10d. INSI | | | 10d. INSIDE CITY LIMITS? |
| | Va. | Accom | ack | | | Onand | cock | 2 | | | | | | 1 YES 2 N |
| FUNERAL | 10e, STREET AND NUMBER | | | | | | | 101, ZIP COD | E | | | 10g. CITIZ | EN OF | WHAT COUNTRY? |
| ij | 31 Kerr St | | | | | | | 2341 | | | | 100 | US | šA |
| BY FU | 11. MARITAL STATUS 1 Never Married 2 Married 3 N Widowed 4 Divorced | ed F | MAS DECEDEN FORCES? 1 F YES, GIVE V | YES : | 2 ANO | IS. WAS DECENDENT OF HISPANIC ORI If yes, specify Cuban, Mexican, Puer 1 YES 2 NO Specify: | | | | | Puerto Rican, atc.) Black, White, at Specify: | | | ffy: |
| ED | 15. DECEDENT | T'S EDUCATION | N . | 10 | Re DECEDE | NT'S USUAL (| OCCUPA- | TION | | 1 404 | VIND OF BUI | SINESS (INDI | HOTOV | White |
| | (Specify only highes Elementary/Secondary (0-12) | ast grade comple | leted) | | (Give kind | d of work done OT use retired.) | during I | most of work | ing | 100 | , KIND OF BU | SINE \$5/INU(| USIRY | |
| COMPLET | 12 | Con | lege (1-4 or 5 · | | Accom | ack Co |) . S | choo. | l Tea | acher | | | | |
| 8 | 17. FATNER'S NAME (First, Middle, Li | Last) | | | | | | _ | | | Middle, Malden | Surname) | | |
| ш | W. Howard Wes | ssells | | | | | | W: | innie | e Cha | andler | Wesse | ells | 3 |
| OB | 19a. INFORMANT'S NAME (Type/Prin | int) | | | 19b. MAII | LING ADDRES | S (Stree | | | | ber, City or Tow | | | |
| 2 | Lynn Massey | | | | 7 | Front | t St | t 1 | Pocon | noke | Md. | 21 | 851 | |
| | 20a METHOD OF DISPOSITION | ☐ Removal fo | rom State | 20b. PL | LACE AND DA | ATE OF OISPO | SITION | Neme of | | OAT | E 20c. LO | | | |
| | 4 Donation 5 Other (Specifi | ⁽⁴ y) | | Mt | E. Hol | y Ce | | | | | 194 0 | nanco | ćk, | Virginia |
| | 21. SIGNATURE OF FUNERAL SERV | VICE LICENSE | E |) | | 22 | . NAME | ANO ADORE | SS OF FA | CILITY | | 94 M | lark | et St. |
| | 10m61 | ill. | ans | | | W | i17 | iams | Onan | cock | F.H. | | | , Va. 234 |
| l li | | | | (OR AS A CO | ONSEQUENC | E OF): | | iden | | | | | | |
| TIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death I AST | { | Arte: | | ONSEQUENC | tic (| | | | ılar | Dise | ase | | |
| CAL CERTIFICATION | if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | e | Arte: | CORASACO | ONSEQUENCE ONSEQUENCE ONSEQUENCE | E OF): tic (EE OF): | Car | diov | ascu | | Dise | AUTOPSY | 24b | AVAILABLE PRIOR T |
| MEDICAL | if sny, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | e | Arte: | CORASACO | ONSEQUENCE ONSEQUENCE ONSEQUENCE | E OF): tic (EE OF): | Car | diov | ascu | | 24a, WAS AN | AUTOPSY RMED? | 24b | AVAILABLE PRIOR T COMPLETION OF CA OF DEATH? |
| MEDICAL | if sny, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant cor | | Arte: | CORASACO | ONSEQUENCE ONSEQUENCE ONSEQUENCE | E OF): tic (EE OF): | Car | diov | ascu | Pert I. | 24a, WAS AN PERFOR | AUTOPSY RMED? | 24b | AVAILABLE PRIOR TO COMPLETION OF CA OF DEATH? |
| MEDICAL | if sny, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DICAL HO | Arte: DUE TO DUE TO DUE TO | TIOSC (OR AS A CO | ONSEQUENCE ONSEQUENCE ONSEQUENCE ONSEQUEN | E OF): EE OF): Ing in the u | Car nderiy | diov | ascu | Pert I. | 24a. WAS AN PERFOF 1 YES 2 | AUTOPSY RMED? | 246 | AVAILABLE PRIOR TO COMPLETION OF CA OF DEATH? |
| MEDICAL | if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant cor | HO: | DUE TO DUE TO DUE TO Tributing to | CIOSC (OR AS A CO | ONSEQUENC | E OF): E OF): E OF): OTHE OTHE A A Nu TIME OF | Car nderly | diov | ascu | Pert I. | 24a. WAS AN PERFOF 1 YES 2 | AUTOPSY MMED? | | . WERE AUTOPSY FIN AMAILABLE PRIOR TI COMPLETION OF CA OF DEATH? 1 YES 2 NO |
| PHYSICIAN: MEDICAL | if ery, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other eignificant con 25. WAS CASE REFERRED TO MEDIE EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pendin | HO: | Arte: DUE TO DUE TO DUE TO SPITAL: Inpetient 2 | CIOSC (OR AS A CO | ONSEQUENC | E OF): EE OF): EE OF): OTHE | 26. R: rsing He | diov | ascu | Pert I. | 24a. WAS AN PERFOR | AUTOPSY MMED? | | AVAILABLE PRIOR T COMPLETION OF CA OF DEATH? |
| BY PHYSICIAN: MEDICAL | if sny, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other eignificant con 25. WAS CASE REFERRED TO MEDIEXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pendin | OICAL HO | DUE TO DUE TO DUE TO DUE TO SPITAL: Inpetient 2 [28e. OATE OF (Month, E) 28e. PLACE C | COR AS A CO O death but ER/Outpatte FINJURY OF INJURY OF INJURY | ONSEQUENC | E OF): LE OF): EE OF): OA 4 Nu TIME OF INJURY M | 26. R: rising H: 1 | DPLACE OF I | ascu | Pert I. eck only or 6 Othe 28d. DE: | 24a. WAS AN PERFOR | AUTOPSY IMEO? I NO | TURED | AMAILABLE PRIOR COMPLETION OF OP DEATH? 1 YES 2 |
| PHYSICIAN: MEDICAL | if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant consequence of the consequence | ng getton not be nined G PHYSICIAN: | DUE TO DUE TO DUE TO DUE TO SPITAL: Inpetient 2 [28a. OATE OF (Month, E) 28a. PLACE Of building, To the best of the bests of e | TIOSC OF AS A CO OF A | ONSEQUENCE | OTHE OF INJURY M | 26. R: 28c. II 20c. II 1 time, do | DIOV Ing ceuse PLACE OF I Ome 5 R NJURY AT WORK? YES 2 [ite and place, death occu | given in | Pert I. Beck only of the Carlotte Carl | 24a. WAS AN PERFOR | AUTOPSY IMED? INJURY OCC and Number of | or Rural I | AMALABLE PRIOR 1 COMPLETION OF C. OF DEATH? 1 YES 2 N |
| BE COMPLETED BY PHYSICIAN: MEDICAL | if sny, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in desth) LAST PART II. Other eignificant con 25. WAS CASE REFERREO TO MEDI EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pendin Investig 3 Suicide 6 Could determ 29a. CERTIFIER (Check only one) 2 MEDICAL ED | ng gestion not be nined G PHYSICIAN: XAMINER: On BRITIFIER SON WHO COR | DUE TO DUE TO DUE TO DUE TO SPITAL: Inpetient 2 [28a. OATE OF (Month, E) 28a. PLACE Of building, To the best of the bests of e | ER/Outpatte ER/Outpatte In y knowledge examination en | ONSEQUENCE | OTHE OF: OTHE OF: INDICATE OF: OTHER OF: INDICATE OF: | 26. IR: 1 28c. II 1 time, do opinion | Dispersion of the series of th | given in DEATH (Cho tasidence NO e, and due tred at the | Pert I. eck only or 6 Other 28d. Det 28f. Loc City to the car ilme, date | 24a. WAS AN PERFOR | AUTOPSY IMED? INJURY OCC and Number of | or Rural I | AMALABLE PRIOR T COMPLETION OF CI OF DEATHY 1 YES 2 N Route Number, |

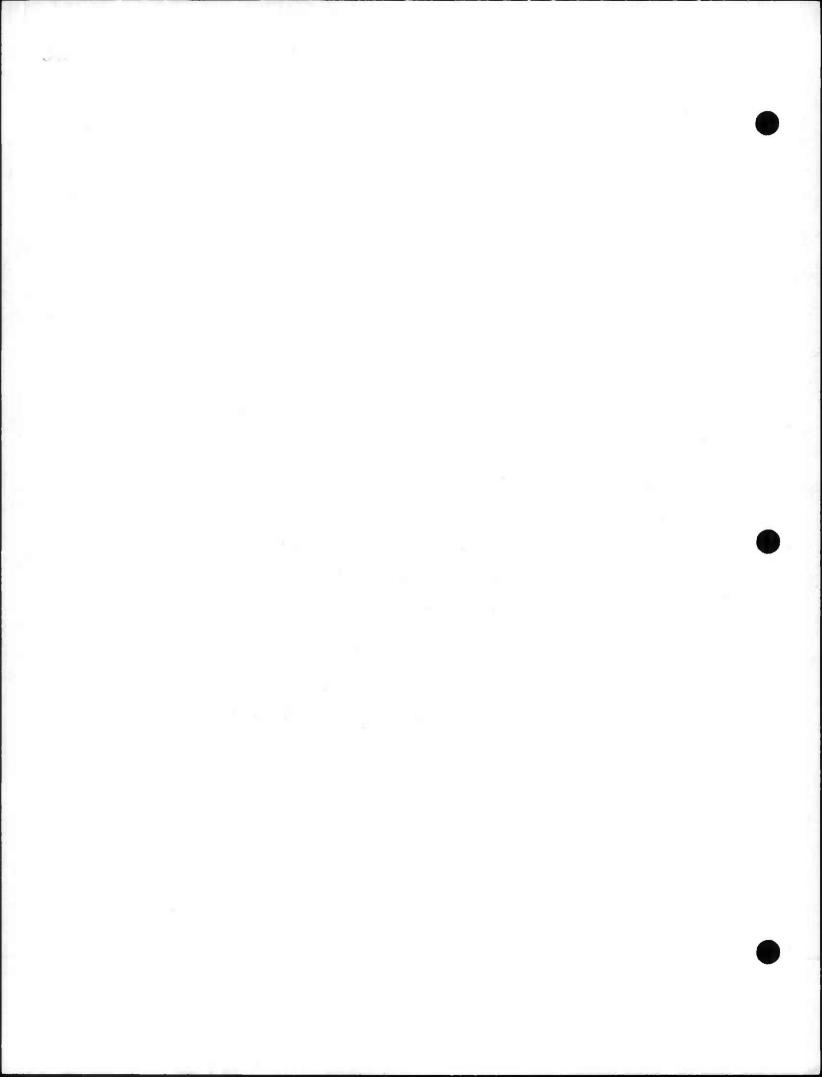
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entropy of the state of the sta

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| | te item 23 shows any injury or other traumatic event, the medical examiner must be notified |
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| ll, cremation, or removal | fleal |
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| e State Dept. of Health and Mental Hygiene prior to buria | 23 |
| tate | fem |
| (3) | - |

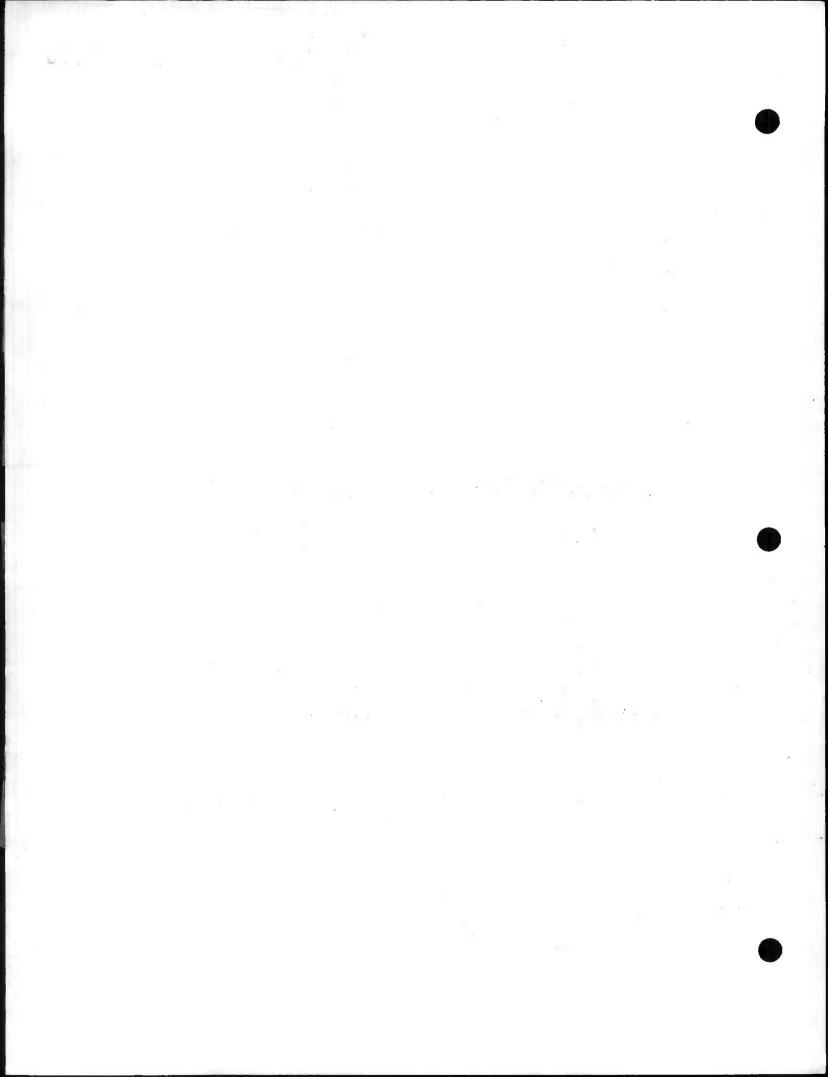
31. DATE FILED (Month, Day, Year) AUG 2 4 1994

| | 1 - FOR STATE REGISTRAR | | STATE OF I | MARYLAND | ERTIF | | | | | MENTA | L HYGIEN REG. NO | E | | |
|------------------------------------|--|---|--|--|--|---|--|--|---|--------------------------|--|--------------------------|----------------------|--|
| 1 | 1. DECEOENT'S NAME (First, | , Middle, Last) | · | | <u> </u> | 104 | | ULA | 111 | | OF DEATN | • | | 3. TIME OF DEATH |
| | Maurice Wes | sely Po | ulmer | | | | | | | Ata | 3ust | 22 19 | YEAR 79 4 | 1419 H |
| | 4. SOCIAL SECURITY NUMBER 215-05-7292 | | 5. SEX 1 [2] M 2 [] F | B. AGE (In yrs.) | last birthday) YRS. | IF UNDER | 1 YEAR DAYS | IF UNDER | MIN. | 7. DATE (Mon | of BIRTH | 908 | BIOTHO | LACE (State or Foreign yland |
| | 9e. FACILITY NAME (If not in | | | 00 | - | 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | | |
| DIRECTOR | Washington | - | y Hospita | rl | | | | | stow | | | | | hington |
| REC | 10e. STATE | 10b. COUNTY | | | 10c, CIT | Y, TOWN O | | | | | | | | 10d. INSIDE CITY LIMITS? |
| <u> </u> | Md. | | Washing | ton | | Smi | | bwrg | | | | | | t TYES 2 X NO |
| ERAL | 12515 Brade | bwry, A | Ave. | | | | 101 | zip cod | 1783 | | | 10g. CITIZI | EN OF WI | AT COUNTRY? |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Merried 2 2 3 Widowed 4 Divo | | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | YES 2 | | 1 | f yes, sp | | m, Mexice | n, Puerto | N? (Specify Yes Rican, etc.) | or No- | Specify | — American Indian, White, etc. |
| ED | | EDENT'S EDU | | | DECEDENT'S (Give kind of | | | | 0.0 | 168 | . KIND OF BU | SINESS/INDU | | |
| COMPLETED | Elementary/Secondary (0 | | College (1-4 or 5 | | ife. Do NOT u | ool N | | | ng | | | Tool | Co. | |
| BE CON | 17. FATHER'S NAME (Flist, M John C. Pad | | | | | | | ts. MOT | HER'S NA Nell | ME (First. | Middle, Maiden Bran | surneme) denbu | rg | |
| 0 | Mae F. Palr | | | | 12515 | Brac | lbwr | nd Number y Av | e. Si | mith | sbor, City or Tow | m, State, Zip (Md. 2 | 1783 | |
| | 20e. METHOO OF DISPOSITI | on 3 🗆 Rem | oval from Stata | | EANDDATE | | | | -25- | 94 °AT | | cation – c ths bu | | |
| 1 | 21. SIGNATURE OF FUNERA | L SERVICE LIC | EHNE | | | 22. 1 | NAME AN | D ADDRE | SS OF FA | CILITY | 105 | 0 E R 4 | adbu | hu Aug |
| | * Hen | nio d | K. Me | ivis | | | Pavi | s Fu | nera | Ł Ho | SIIK | rissu | rg,M | ry Ave. Id. 21783 |
| | 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ahock, pr heert failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition | | | | | | | | | | | | | |
| | IMMEDIATE CAUSE (Fir | | List only ona cau | use on each li | ne. | | | | | | | | st, | Approximate Interval Batween Onset and Death |
| Z | iMMEDIATE CAUSE (Fir disease or condition resulting in death) | nei → | List only ona cau | use on each li | ne. | | | | | | | | st, | Interval Batween |
| CATION | iMMEDIATE CAUSE (Fir disease or condition resulting in death) Sequentially list condit if any, leading to immecause. Enter UNDERLY! | lona, diate ING | List only ona cau | use on each li | ne. | | Ar Ar | res | | | | | st, | Interval Batween |
| ERTIFICATION | iMMEDIATE CAUSE (Fir disease or condition resulting in death) Sequentially list condit if any, leading to imme- | lona, diate iNG | e | use on each li | EQUENCE O | c + | Ar Ar | res | | | | | st, | Interval Batween |
| L CERTIFICATION | iMMEDIATE CAUSE (Fir disease or condition resulting in death) Sequentially list condit if any, leading to immecause. Enter UNDERLY! CAUSE (Disease or injuthet initiated eventa resulting in death) LAS | llona, diate in G | e | (OR AS A CONS | EQUENCE O | e f | Ar Ar | res ter | y | 20 | cesy | | | Interval Batween Onset and Daath |
| _ | iMMEDIATE CAUSE (Fir disease or condition resulting in death) Sequentially list condit if any, leading to immecause. Enter UNDERLY! CAUSE (Disease or injut that initiated eventa | llona, diate in G | e | (OR AS A CONS | EQUENCE O | e f | Ar Ar | res ter | y | 20 | cesy | AUTOPSY MMED? | 246. \ | Interval Batween |
| MEDICAL | iMMEDIATE CAUSE (Fir disease or condition resulting in death) Sequentially list condit if any, leading to immecause. Enter UNDERLY CAUSE (Disease or injuthet initiated eventa resulting in death) LAS PART II. Other significe | diona, diate iNG pry | e | (OR AS A CONS | EQUENCE O | P): | Av Av | res fer | given in | Pert I. | 24a. WAS AN PERFOR | AUTOPSY MMED? | 246. \ | Interval Batween Onset and Daath Onset and Daath WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDICAL | IMMEDIATE CAUSE (Fir disease or condition resulting in death) Sequentially list conditi if any, leading to immecause. Enter UNDERLY! CAUSE (Disease or injuthet initiated eventa reaulting in death) LAS PART II. Other significe DID TOBACC 25. WAS CASE REFERRED TO | lona, dilate ING pry ST | e | (OR AS A CONS | EQUENCE O | P): | Av Av OS | res fer s | y | Pert I. | 24a. WAS AN PERFOF | AUTOPSY MMED? | 246. \ | Interval Batween Onset and Daath Onset and Daath WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | iMMEDIATE CAUSE (Fir disease or condition resulting in death) Sequentially list conditi if any, leading to immercause. Enter UNDERLIV CAUSE (Disease or injuthet initiated eventa resulting in death) LAS PART II. Other signification. | lona, dilate ING pry ST | e | (OR AS A CONS (OR AS A CONS O death but not | EQUENCE O | F DEA | TH 28. PL | TES [ACE OF D | given in | Pert i. | 24a. WAS AN PERFOF t YES 2 | AUTOPSY MMED? | 246. \ | Interval Batween Onset and Daath Onset and Daath WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
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| BALTIMORE, MARYLAND 21215-0020 | nours after death. Page 6 may be retained by the hospital or attending physician. | the annual signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per managed by the annual House Managed by the attending physician and Montal House Managed by the attending physician and Montal House Managed by the attending physician and Montal House Managed by the attending physician and Montal House Managed by the attending physician and Completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per managed by the attending physician and the attending physician and the attending physician and the attending physician and the attending physician and the attending physician and the attending physician and the attending physician and the attending physician and the attending physician and the attending physician and the attending physician attending physician and the attending physician attending physician and the attending physician attending physician and the attending physician and the attending physician attending physician attending physician and the attending physician attendi | II, Ul fefficial. | e medical examiner must be notified at once. |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE HOSPITAL DR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per management of physician and should be attended for use as the burial-transit per management of the should be detached for use as the burial-transit per management of the should be attended for use as the burial-transit per management of the should be attended for use as the burial-transit per management of the should be attended for use as the burial-transit per management of the should be attended for use as the burial-transit per management of the should be attended for use as the burial-transit per management of the should be attended for the should be attended for use as the burial-transit per management of the should be attended for the should | oe med wull /2 hours are death with the state Dept. Of hearth and mental hygiene prot to build, cremator, of enhoar | IMPORIANI: II liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1. DECEDENT'S NAME (First | | | | | | | | | 2. DATE OF DEATH | | | 3. TIME OF DEAT | Н |
|---|---|---------------------------------|---------------------------|--------------------------------------|--------------|--------------|------------|------------------|------------------------|---|----------------------|-----------------|--------------------------------------|-------|
| | RICHA | RD MEF | RLE POWEL | L, SR. | | | | | | AUGUST 2 | 26, 19 | 99 ⁴ | 5: 50 | PM |
| | 4. SOCIAL SECURITY NUME | BER | 5. SEX | 6. AGE (In yrs. las | t birthday) | IF UNDER | 1 YEAR | IF UNDE | R 24 HRS. | 7. DATE OF BIRTH | | 6. BIRTI | HPLACE (State or Fo | reign |
| | 219-20-1761 | | 1 M 2 F | 68 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, Day, Year) May 10 1 | 026 | Count | ryland | |
| | 9a. FACILITY NAME (If not in | | reet and number) | | | 9b. CITY | , TOWN (| OR LOCAT | ION OF DE | | | UNTY OF D | - | |
| оместов | JOHNS HO | PKINS | | | | | LTIN | | CIT | | 1000 | ltim | | |
| CC | RESIDENCE OF DEC | 10b. COUNTY | , | | 10c. CIT | Y, TOWN C | R LOCAT | ION | | | | | 10d. INSIDE CITY | |
| E | Maryland | | Washingto | on | | ager | | | | | | | LIMITS? | |
| 77. | 10a. STREET AND NUMBER | | | | | 0 | _ | ZIP COD | DE | | 10g. Cl | TIZEN OF | WHAT COUNTRY? | 140 |
| FUNERAL | 10804 Downs | sville | Pike | | | | | 2174 | | | | S.A | | |
| 3 | 11. MARITAL STATUS | 371110 | 12. WAS DECEDEN | T EVER IN U.S. AR | MED | 13. | WAS DEC | | | IC ORIGIN? (Specify | | 14. RAC | E - American India | n. |
| BY F | 1 Never Married 2 X | | FORCES? 1 | Y YES 2 1 | 10 | | If yes, sp | ecify Cub | sn, Maxical Specify | , Puarto Rican, etc.) | | Spec | k, White, atc. | |
| | W.W. II | | | | | | | | | | | | White | |
| COMPLETED | 15, DEC (Specify only | EDENT'S EDUC y highest grade | CATION completed) | (G | CEDENT'S | work done | CCUPATIO | ON st of work | ing | 16b. KIND OF I | USINESS/IN | DUSTRY | | |
| ا پ | Elamentary/Secondary (0 | 1-12) | Collega (1-4 or 5 | +) | Do NOT us | sa retired.) | | | | D - 41 | 1 | | | |
| ğ | 17. FATHER'S NAME (First, M | liddle Leet | | | hief | Cal. | rer | Tec. : | | | road | | | |
| | Harry James | | 1 1 | | | | | | | ME (First, Middle, Maid | en Surname) | | | |
| BE | 19a. INFORMANT'S NAME (7 | | | | MAII IOO | ADDRESS | . /5 | | | ie Biser | - | - 0 | | |
| 임 | | | ovio 1.1 | | | | | | | oute Number, City or 1 | | | 017/0 | |
| | Carrie C. I | ION | | 20b. PLACE | | | | | Pik | e Hagers | town, | | | |
| | 1 X Burial 2 Cremation 4 Donation 5 Other | n 3 🗆 Reme | oval from Stata | cemetery, cre | metory or of | ther plecel | | | ark | B-30-94 | | | ., | an d |
| | 21. SIGNATURE OF FLINERA | | ENSEE | Cedar | Lawi | | | | SS OF FAC | II ITV | | | | and |
| | STA | 211 | m | mull | a. | Minnich Fur | | | | | | | | |
| _ | | 4-1 | 1100 | rince | | | | | | | | | Maryla | nd |
| | 23. PART i. Enter the di shock, or he | eart failure. | Liet only one cau | it ceused the de ise on each iine | eth. Do n | not enter | the mo | de of dy | ring, such | ea cerdiec or re- | piratory a | rrest, | Approxima | |
| ł | iMMEDIATE CAUSE (Fir disease or condition | nel | M | 11: | / | | | | / | γ_{I} | | | Onset and | |
| | resulting in death) | → , | . // (| Jet Sy | ster | n (| (Q) | 7 a | - + | acture | | | (0a | 04 |
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| CERTIFICATION | Sequentially list conditi | | | OF AS A CONSE | DUENCE OF | FI: | | A. | | 1 1 | | | (00 | ay |
| ¥ | if any, leading to imme- cause. Enter UNDERLY! | ING | Sto | tis nos | 2 | | 77 00 | 100 | (9 | Reed | | | 150 | 0 |
| Ĕ | CAUSE (Disease or inju | iry 🥻 ' | DUE TO | (OR AS A CONSEC | DUENCE OF | | . 00 | | | | | | (10 | acq |
| E | resulting in deeth) LAS | т . | 1. | U | | | | | | | | | | |
| | PART II Other cleatifica | nt operation | e anni di cata a c | de ale le c | | | | | | | | | | |
| DICAL | PART II. Other eignifice | Condition | s contributing to | | tztu | | 1 | ceuse | given in | Part I. 24a. WAS | NN AUTOPSY ORMED? | 248 | . WERE AUTOPSY FII AMILABLE PRIOR | ro |
| ă | MIDDM | 1 -1 | rautis | 13/2 | 4500 | 1 /2 | 054 | U | Lovely | THE YES | 2 NO | 77 | COMPLETION DF C DF DEATH? | AUSE |
| ME | DID TOPACO | decti | | F TO | ICE | V | 711 | /PA - | | | | | 1 YES 2 N | 10 |
| PHYSICIAN: | DID TOBACC | | COMIKIROI | E 10 CAL | ISE O | r DEA | | | | | | | | |
| 호 | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOSPITAL: | | | OTHER | | ACE OF E | DEATH (Che | ck only one) | | | | |
| ₹ | 1 TYES 2 NO | | t Inpetiant 2 | ER/Outpatiant 3 | _ | 4 🗆 Nun | aing Hom | | aaldenca | 8 Other (Specify) | | | | |
| | 27. MANNER OF DEATH | Pending | 26a. DATE OF (Month, D | lay, Yeer) | 26b. TIM | E OF URY | | RK? | _ ,,,, | 26d. DESCRIBE HON | VINJURY O | CCURED | | |
| ה ו | 2 Accident | Investigation | 44 - PI 400 0 | | | | | /ES 2 [| NO | | | | | |
| | | Could not be datarmined | building, | F INJURY — At ho atc. (Specify) | me, farm, s | street, fact | ory, offic | • | | 26t. LOCATION (Stree City or Town, Sta | et and Numbe (e) | er or Aural | Route Number, | |
| <u>.</u> | 20-050515150 | | | | | | | | | | | | | |
| 를 | | | | | | | | | | to the cause(a) and n | | | | |
| COMPLET | 2 MEDI | | | xamination and/or i | investigatio | n, in my o | pinlon, d | eath occu | red at the | lime, deta and placa, | and dua to t | tha cause(| s) and manner as st | ated. |
| BE (| 29b. SIGNATURE | OF CERTIFIER | 15 | | | | | 29c, LIC | ENSE NUM | BER | 29d, DA | TE SIGNED | (Month, Day, Year) | |
| ö | 1 20 | - | <u> </u> | | | | | AI | 414 | 7157 1720 | 14 | 2/2 | 6/94 | |
| | 30. NAME AND ADDRESS OF | | COMPLETED CAU | SE OF DEATH (ITE | M 27) (Type, | Print) | 1 | RI | 1. | 7357 BZC | 0.45 | | | |
| | | ns | Johns | Hoflens | 1405 | ert | 1 | Jal | mon | e, ma | 215 | 05 | | |
| 31. DATE PILED (MORIN, Day, Teary 32. RE ISTMAR'S SIGNATURE | | | | | | | | | | | | | | |
| | AUG 2 | 9 1994 | Calino | evendent of | andall | - | | | | | | | | ł |



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| LTIMORE, MARYLAND 21215-0020 | ith. Page 6 may be retained by the hospital or attending pl | neral director, page 5 should be detached for use as the bunal-transi | |
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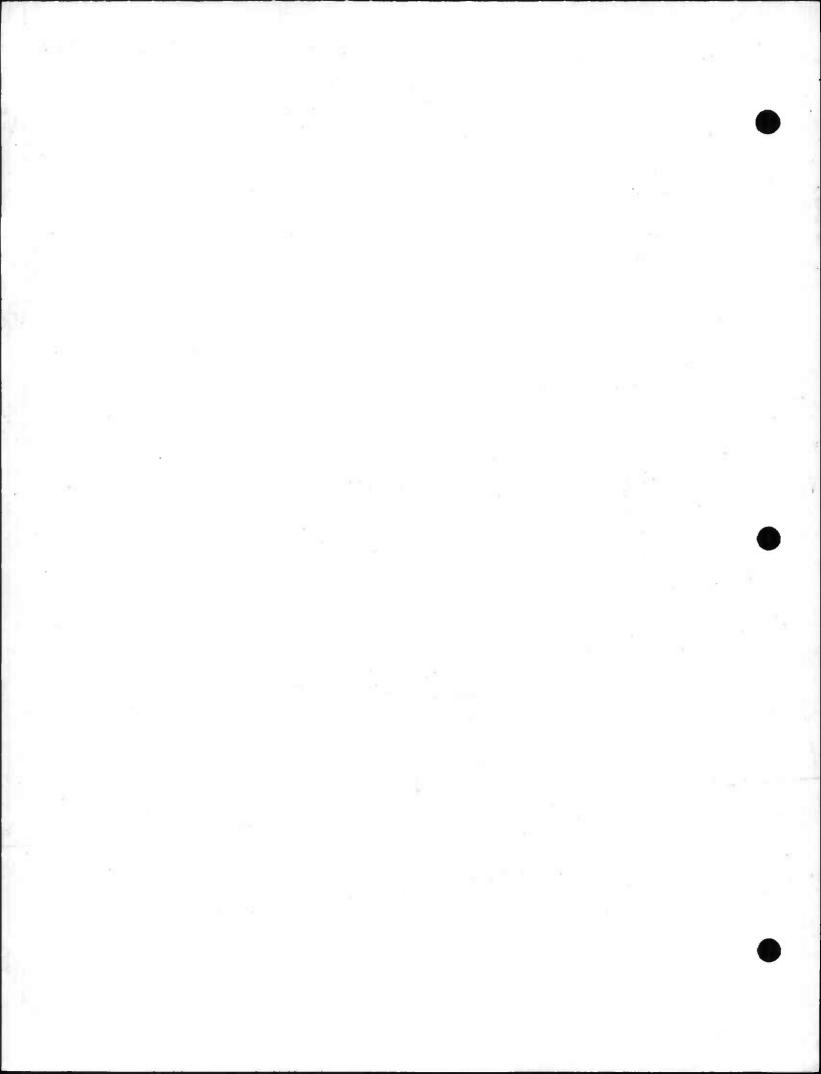
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CI | RIF | CATE | OF D | EATH | RE | EG. NO. | | | |
|----------------------|---|--|----------------------------------|---|--|----------------------|------------------------------|------------------------------|-----------------------|-----------------|-------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 1 Destri | | | - | | | 2. DATE OF O | EATH DAY | | YEAR | 3. TIME OF DEATH |
| | | leen PHIL | | | | | | August | 26, | 199 |) 4 | 9:00 P M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. las | | MONTHS D | | UNDER 24 HRS. | 7. DATE OF BI | HTH (Mar) | | 8. BIRTH Count | IPLACE (State or Foreign |
| | 220-18-1507 | 1 M 2 💢 F | 91 | YAS. | | | JUNE MIN. | Sept.20 | 0,190 | 02 | Wes | t Virginia |
| | 9a. FACILITY NAME (If not institution, give a | | | | 96. CITY, TO | WN OR L | OCATION OF DE | ATN | | 9c. COU | NTY OF D | EATH |
| FUNERAL DIRECTOR | Ravenwood Nursin | g Home | | | | Ha | agersto | wn | | Wa | shin | gton |
| S | 10a. STATE 10b. COUNT | Y | | 10c. CITY | , TOWN OR L | OCATION | | | _ | | | 10d. INSIDE CITY |
| 8 | Maryland Wash | ington | | | На | oare | stown | | | | | LIMITS? 1 YES 2 NO |
| 7 | 10a. STREET AND NUMBER | 11160011 | | | 110 | _ | P CODE | | | 10n CIT | IZEN OF 1 | WHAT COUNTRY? |
| <u> </u> | 1826 Heisterboro | Road | | 21740 | | | | | | | SA | |
| 3 | 1t. MARITAL STATUS | 12. WAS DECEDENT | EVER IN U.S. AR | MED | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify | | | | | | | |
| BY F | 1 Never Married 2 Merried | FORCES? 1 | YES 2 X | 10 | If ye | YES 2 | y Cuban, Mexicar | n, Puerto Rican, | etc.) | | Spec | |
| | 3 🔀 Widowed 4 🗌 Divorced | | | | | | | | | | whi | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | | /G | ive kind of w | USUAL OCCU | PATION ig most of | f working | 16b, KINC | OF BUSI | NESS/INI | DUSTRY | |
| <u>u</u> | Elementary/Secondary (0-12) | Do NOT us | | ١. | | | | | | | | |
| MP | | 0 | | labo | rer | | | | craft | | | |
| | 17. FATHER'S NAME (First, Middle, Last) William Edison Re | ođ | | | | .18 | . MOTHER'S NAM | | | | | |
| BE | 19a, INFORMANT'S NAME (Type/Print) | eu | | | | | | Retta l | | | | |
| 2 | Jean Kiser | | | | | | Number or Rural R Willian | | | | | 1705 |
| | 20a. METHOD OF DISPOSITION | | | | F DISPOSITIO | | | | | | | |
| | 1X Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify) | matory or ot | her place) | | | | | | - City or Town, State | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | t Hav | en Cer | | TY 8- | -30-941 | Hag | ersi | stown, Maryland | | |
| | De Att | nM. | 1 | 22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME | | | | | | | | |
| | 415 E.Wilson Blvd., Hagerstown, Md. 21740 | | | | | | | | | d.21740 | | |
| | 23. PART I. Enter the diseases, or shock, or heart fellure. | complications that List only one caus | causad the de se on each lina | ath. Do n | ot enter the | mode | of dying, auch | aa cardiac (| or reapire | story ar | reat, | Approximata Interval Between |
| | IMMEDIATE CAUSE (Final | • | 10:1 | 1, | Do wester | | | | | | | Onset and Death |
| | disease or condition resulting in death) | a | Dun | 1 | Dululu- | | | | | | | |
| | | DUE TO | OR AS A CONSEC | DUENCE OF |): | | | | | | | |
| ON | Sequentially list conditions, | b. DUE TO (| OR AS A CONSEC | DIJENCE OF | 0. | | | | | | | |
| A | If any, leading to immediate cause. Enter UNDERLYING | 302 10 (| OH AS A CONSE | JOENGE OF |)- | | | | | | | |
| 윤 | CAUSE (Disease or Injury that initiated events | c. DUE TO (| OR AS A CONSEC | EQUENCE OF): | | | | | | | - | |
| E | resulting in death) LAST | 4 | | | | | | | | | | ļ |
| 8 | | 1 | | | | | | | | | | |
| EDICAL CERTIFICATION | PART II. Other algorificant condition | ns contributing to | death but not r | esulting i | n the under | lying ca | use given in i | Part I. 24a. | WAS AN A | | 24b | . WERE AUTOPSY FINDINGS AMILABLE PRIOR TO |
| 8 | | mypule | weer | IA | | | | 10 | YES 2 [| □ NO | | COMPLETION OF CAUSE OF DEATH? |
| ME | | 7/1 6 | 44 | VH | | | | _ | | | | t 🗌 YES 2 🗌 NO |
| ÿ | | 1/ | | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER: | 6. PLACE | OF DEATN (Che | ck only one) | | | | |
| YSI | 1 YES 2 1-HO | t Inputiant 2 | | | 4 Nursing | | i ☐ Residenca i | 8 Other (Spe | city) | | | |
| | 27. MANNER OF DEATH 1 Natural 5 Pending | 28a. DATE OF I (Month, Da | | 28b. TIMI INJI | URY | WORK? | | 28d. DESCRIB | E NOW IN | JURY OC | CURED | |
| B≺ | 2 Accident Investigation | DA- BLACE OF | ' tas segment | | | | 2 NO | | | | | |
| 8 | 3 Suicide 8 Could not be 4 Nomicide datermined | building, e | INJURY — At ho Mc. (Specify) | me, ferm, a | treet, factory, | office | 1 | 28f. LOCATION City or Tow | | id Numbe | r or Rural F | Route Number, |
| | 290. CERTIFIER | | | | | | | | | | | |
| COMPLETED | (Check only | ICIAN: To the best of r | | | | | | | | | | |
| <u></u> 8 | 2 MEDICAL EXAMINE | | aminution end/or i | nvestigation | n, in my opini | on, death | occured at the t | time, date and p | place, end | dua lo ti | ne Cause(e | e) end manner as atated. |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIE | Plan m | 0 | | | 20 | LICENSE NUM | BER | | 29d, DAT | E SIGNED | (Month, Day Year) |
| 2 | ONTHUE! | Man Ul | | | 100 | 1 | 1300 | 200 | | • | 8/6 | 71461 |
| | 30. NAME AND ADDRESS, OF PERSON WH | O COMPLETED CAUS | OF DEATH (ITE | у 27) (Туре, | Print) | oge | Atall. | n MI | 01 | 1/ | 140 |) |
| | 31. DATE FILED (Month, Day, Year) | The second second | 'S SIGNATURE | | 111 | 9 | * | | - 0 | | - | |
| | AUG 2 9 1994 | Julia San | ism then | hal | | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760



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| DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital | DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
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| DR | DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral. |
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TO THE HOSPITAL C TO THE FUNERAL D be filed within 72 ho IMPORTANT: If its

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29h SIGNATURE AND TITLE OF DERTIFIS

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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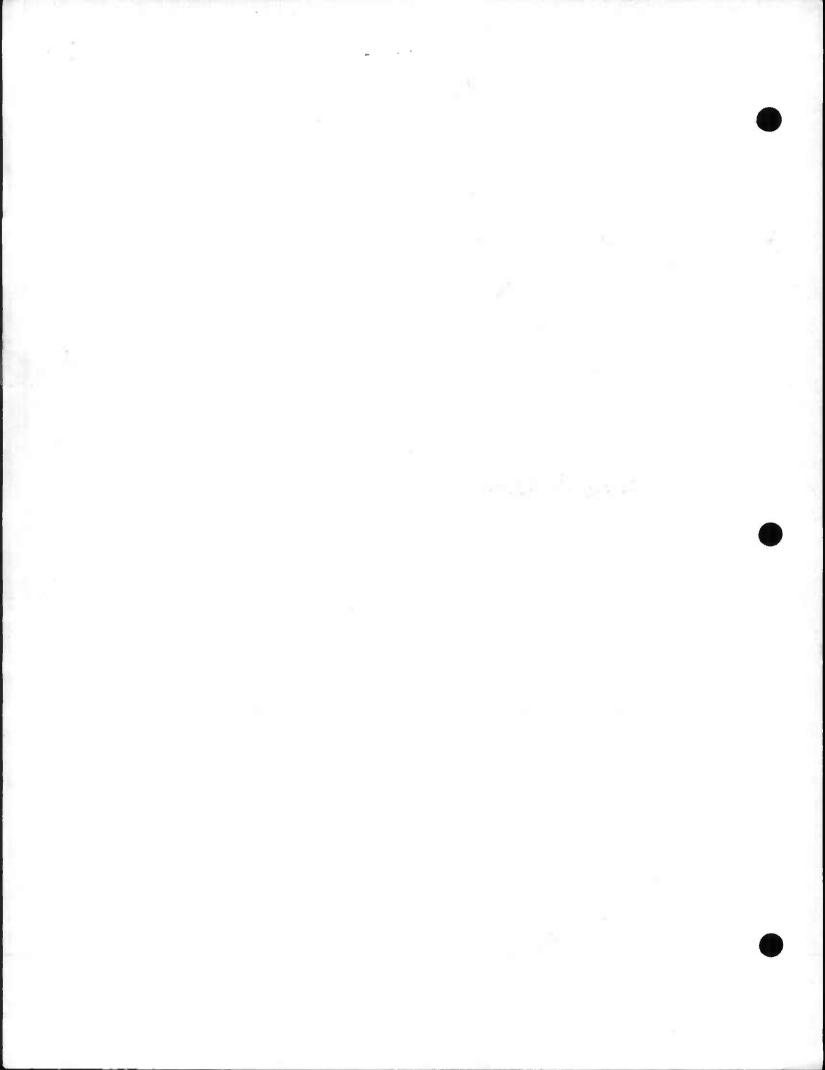
BALTIMORE, MARYLAND 21215-0020

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH VEAR Florence Laverne PECK 8 1994 8:01 A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS BIRTHPLACE (State or Foreign Country) DAYS HOURS 1 M 2 X F 79 VRS 216-66-0893 July 13, 1915 Pennsylvania 9e. FACILITY NAME (If not Institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH DIRECTOR Garrett County Memorial Hospital 0akland Garrett RESIDENCE OF DECEDENT 10b. COUNTY IDC CITY TOWN OR LOCATION 10d. INSIDE CITY MD Garrett 0akland 1 YES 2 X NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Rt. 3, Box 5195 21550 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO If yes, specify Cuban, Mexican, Puario Rican, atc.) 1 Never Married 2 Married 1 YES 2X NO Specify: В Specify: 3 🔀 Widowed 4 🗌 Divorced White ETED 15. OECEDENT'S EDUCATION 18a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highes Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12th Housewife Home once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) 품 BE Lawrence Paxton Melda Cerfoss notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Jonas R. Peck 112 D St., Mt. Lake Park, Maryland 21550 pe 20a. METHOD OF DISPOSITION
1 🔀 Burial 2 🗌 Cremetion 3 🗍 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must b OATE cemetery, crematory or other place)
Garrett Co. Mem. Gardens 4 ☐ Donetion 5 ☐ Other (Specify) 8/20 Oakland, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSES examiner 22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, MD 21550 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fallura. List only one cause on each ilna. intarval Between IMMEDIATE CAUSE (Final Onset and Daath the disease or condition resulting in death) Ventricular Arrhythmia, Acute 1 hour event, DUE TO (OR AS A CONSEQUENCE OF): Ischemic Heart Disease traumatic CERTIFICATION Sev. Years Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, laading to immediate cause. Enter UNDERLYING Arteriosclerotic Cardio-Vascular Disease Unknown CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 6 injury, PART ii. Other aignificant conditions contributing to death but not reaulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? эпу 1 TES 2XXNO shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES TO NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Item **EXAMINER?** HOSPITAL: YES 2 NO OTHER: 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 Nursing Home 5 Realdence 8 Other (Specify) 10 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c, INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1X Natural 5 Pending 1 YES 2 NO DIRECTOR: After the hours after death v Item 28 is mark ВУ Investigation 2 Accident 28a. PLACE OF INJURY — At home, term, straet, factory, office building, atc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide ED 8 Could not be 4 Homicide determined

1 _ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) and manner as stated.

2-XMEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and pieca, end due to the cause(a) and manner as stated.

29c. LICENSE NUMBER 29d. DATE SIGNED (Month. Day. Year) lon D 05658 August 17, 1994 36. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Herbert H. Leighton, M,D., 502 E. Oak Street, Oakland, Maryland 21550 32. REGISTRAR'S SIGNATURE Develor Ro



FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1 - STATE REGISTRAR | C | | | F DEATH | REG. NO | | | | | |
|------------------|--|---------------------------------|----------------------|--------------------------------|--|--|-----------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) LANCE LEE 7 | | | ON | | 2. DATE OF DEATN | MY 23 | YEAR 94 | 3. TIME OF DEATH | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 1 M 2 F 98. FACILITY NAME (If not institution, give street and number) | 8. AGE (In yrs. In | et birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | HOURS MIN. | 7. DATE OF BIRTN (Month, Day, Year) | | Count | | | |
| TOR | SPA CREEK MERIDIAN NU | RSING | CENT | | NNAPOLI | | 9c. COL | ANN | E ARUNDEL | | |
| FUNERAL DIRECTOR | 10e. STATE 10b. COUNTY MARYLAND ANNE ARUN | DEL | 10c. CITY | TOWN OR LOC | NOLD | | - | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | |
| IEËAL | 100. STREET AND NUMBER 791 HARMONY AVENUE | | | | 10f. ZIP CODE 2101 | 2 | 10g. CIT | | WHAT COUNTRY? U.S.A. | | |
| В | 11. MARITAL STATUS Never Married 2 Married 12. WAS OECEDEN FORCES? 1 15 15 15 15 15 15 15 | YES 2 V | RMED NO | If yes, | ECENDENT OF HISPAN specify Cuban, Mexica ES 2 NO Specifi | | a or No- | 14. RACE — American Indian, Black, While, atc. CAUCASIAN | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSIN | | | | | | | | DWATME | | |
| JMC | 12+ | | LA | BORER | T 40 MOTHERIO NA | ME (First, Middle, Maide | | 30 V E | RNMENT | | |
| | GILBERT PARKINSON | | | | | | LLF. | 2 | | | |
|) BE | 19a. INFORMANT'S NAME (Type/Print) | 19 | b. MAILING | ADDRESS (Stree | | Route Number, City or Tox | | | | | |
| 2 | MR. & MRS. GILBERT PA | | | | | VENUE AR | | | D 21012 | | |
| | 20a. METNOD OF DISPOSITION 1 □ Burlel 2 ☒ Cremetion 3 □ Ramoval from State | | AND DATE O | F DISPOSITION (| Neme of | DATE 20c. L | CATION - | City or To | wn, Slata | | |
| - 1 | 4 Donation 5 Other (Specify) | | | EMATO | | | BALT | CIMO | RE, MD | | |
| | Comes Etho | llan | 28 | BAI | | SONS FU | | | | | |
| CERTIFICATION | 23 (PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory streat, interval Bat Onset and Interval Bat Onse | | | | | | | | | | |
| DICAL | PART II. Other significant conditions contributing to | desth but not | resulting la | the underly | ing cause given in | Part I. 24e. WAS AI PERFO | RMED? | 24b | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO | | |
| PHYSICIAN: MEI | DID TOBACCO USE CONTRIBUTE | TO CAU | SE OF | DEATH | YES NC | | | | 1 1 123 2 110 | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | | | | PLACE OF DEATH (Ch | eck only one) | | | | | |
| YSI | 1 YES 2 NO 1 Inpatient 2 | | _ | | ome 5 - Residence | 6 Other (Specify) | | | | | |
| ВУ РН | 27. MANNER OF DEATN 1 Natural 5 Pending (Month, D | ay, Ybar) | 28b. TIME INJU | M 1 | NJURY AT YORK? YES 2 NO | 26d. DEŞCRIBE HOW | INJURY OC | CURED | | | |
| | 4 Homicide determined building, | F INJURY — At he atc. (Specify) | ome, farm, st | reet, factory, of | lice | 28f. LOCATION (Street City or Town, State | | or Or Rural I | Route Number, | | |
| COMPLETED | 29e. CERTIFIER (Check only one) CERTIFYING PNYSICIAN: To the best of one) MEDICAL EXAMINER: On the basis of one | | | | | | | | i) and manner as stated. | | |
| TO BE (| 396. BICHARDERIE AND TITLE OF CENTRIER | mo | | | D 4/1 | | 29d. DAT | 8/2 | (Month/Day, Year) | | |
| | Charles W. Phelps MD | 180 A | dunina | 101 | me Dr. | Annapoli | s N | 10. | 2140/ | | |
| | 1110 0 11 10 1 | R'S SIGNATURE | rdell | | | | | | | | |
| | | | | | | | | | DHMH-16 Rev 1/89 | | |

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Level LEE PARK WS-N E SE SY 318-76 335Y 35 14-44-41

FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CERTIF | CATE | OF | DEAT | ГН | R | EG. NO. | | | |
|---|---|--|--|---------------|---------------------------|-----------|-----------|-------------------------------------|--|----------|---------------|---|
| , | 1. DECEDENT'S NAME (First, Middle, Last) | RONDI PIC | KFORD | | | | | 2. DATE OF I | DAY | 4 | YEAR | 3. TIME OF DEATH |
| | 219-82-6136 | □ M 2 X xF 2 | E (In yrs. last birthday) 9 YRS. | | DAYS | IF UNDER | MIN. | 7. DATE OF E (Month, De 7 4 1 | 965 | | MA | RYLAND |
| DIRECTOR | 98. FACILITY NAME (If not institution, give stree 1175 MADISON STRE) | | 3 | ANNA | | | ON OF DE | ATH | | | NE A | EATH RUNDEL |
| ည္အ | 10a. STATE 10b. COUNTY | | 10c. CITY | , TOWN OR | LOCAT | ION | | | | | | 10d, INSIDE CITY |
| | MARYLAND ANNI | E ARUNDEL | Al | NNAPO | | ZIP COD | - | | | | | LIMITS? |
| PUNERAL | 1175 MADISON STRE | ET APT. A3 | | | | 2140 | | | | | .S. | VHAT COUNTRY? |
| B | 11. MARITAL STATUS 1 X Kever Married 2 Married 3 Widowed 4 Divorced | R IN U.S. ARMED S 2 XXVO DATES | ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 YES 2 XXO Specify | | | | | | Yes or No — 14. RACE — American Indian, Black, White, atc. Specify: RI.A.C.K | | | |
| ETED | 15, DECEDENT'S EDUCAT (Specify only highest grade col Elementary/Secondary (0-12) | USUAL OCC rork done du e retired.) | | | ng | 16b. KIN | D OF BUS | INESS/IN | | LALL | | |
| 를 | | | UNEMPLO | YED | | | | | | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOT | HER'S NAI | ME (First, Middle | a, Maiden S | Surname) | | |
| BE | JAMES PICKFORD | | | | | S | HIRL | EY HAW | KINS | | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | | 1 | | | | | loute Number, C | | | | |
| | SHIRLEY HAWKINS | | | | _ | | APT. | | | | | 21403 |
| | 20a. METHOD QF DISPOSITION 1 | from State | ob.PLACEAND DATE C emetery, cremetory or ot ETRO CREMA | | | me or | 8/] | DATE 6/94 | | | RE, | |
| į | 21. SIGNATURE OF FUNERAL SERVICE LICEN | | > | 22. N | AME AN | | SS OF FAC | MORTUA | | | | |
| | Harry | J. Xe | 220 | | | | | ANNAPO | | | 214 | 01 |
| | 23. PART I. Enter the diseases, or con- ehock, or heart fellure. Lis IMMEDIATE CAUSE (Final disease or condition resulting in death) a. | END-S | each lina, The same of the sa | CIR | | | | | | | | Approximate Interval Between Onset and Death |
| HIIFICATION | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | | S A CONSEQUENCE OF | | | | | | | | | |
| CERT | resulting in death) LAST | | | | | | | | | | | |
| | PART II. Other eignificent conditions of | ontributing to deeth | but not resulting i | n the und | lerlying | ceuse | given in | Pert I. 24a | . WAS AN A | | 24b | . WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO |
| MEDICAL | | | | | | | | 1[| YES 2 | | | COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO |
| ž | | | | | | | | | | | | |
| | | IOSPITAL: | | OTHER: | | ACE OF D | EATH (Che | ock only one) | | | | |
| 148 | 1 YES 2 TO 1 | 28a. DATE OF INJUR | | 4 - Nursi | ng Hom | - | sidence | 6 Other (Sp | , , | | | |
| BY PHYSICIAN: | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year | | | 28c. INJU WOI 1 Y | RK? | NO | 28d. DESCRII | SE HOW IN | JURY OC | CURED | |
| | 3 Suicide 8 Could not be determined | 28a. PLACE OF INJU building, atc. (S) | RY — At home, farm, a pecify) | treet, factor | ry, offica | | | 28f. LOCATIO City or To | N (Street ar wn, State) | nd Numbe | or or Rural I | Route Number, |
| 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | | | | | | | | | a) and manner as stated. | | | |
| O BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | - 20 | | | | 29c. LICI | HI 6 | 9BER | | 29d. DAT | SIGNED | (Month, Day, Year) 6-94 |
| | 30. NAME AND ADDRESS OF PERSON WHO C | A | DEATH (ITEM 27) (Type, | | -15 | M | p | 214 | 101 | | | |
| | AUG 22 199 | 32. REGISTRAR'S SI | WOLAT RANGE | lf ` | | 1 | | | | | | |

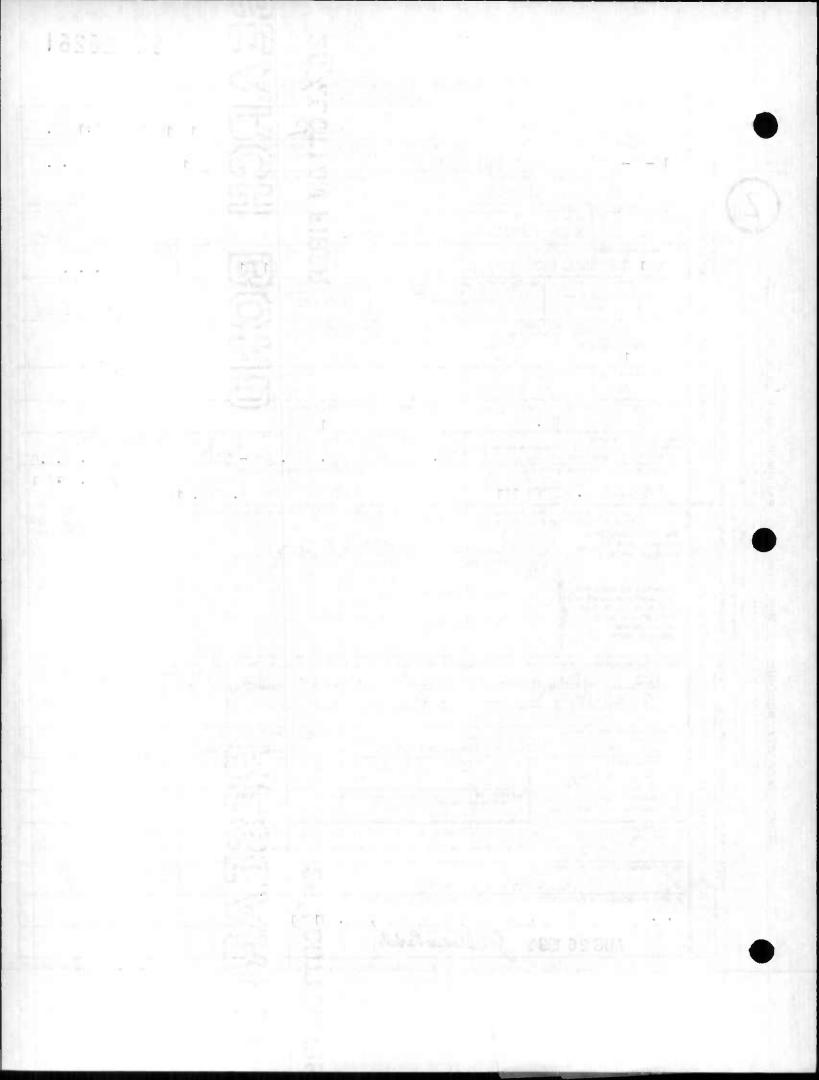
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a four after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-trans be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to buriat, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| . BOX 68760, BALTIMORE, MARYLAND 21215-00; | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Fours after death. Page 6 may be retained by the hospital or attending ph | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bube filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the dea | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, |

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENT | AL HYGIEN |
|---|-----------|
| CERTIFICATE OF DEATH | REG. NO. |

| FOR STATE REGISTRAR | STATE OF MARY | | RTMENT OF H | | MENTAL HYGIEN | | |
|--|---|--|--|-----------------------------|---|---------------------|---|
| | AVICTORIA | PARKER | PARKE | ER | 2. DATE OF DEATH | 1994 | 3:10 P. |
| 4. SOCIAL SECURITY NUMBER 213-34-4476 9a. FACILITY NAME (If not institution, give | 1 M 2 Typ | 64 YRS | MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | | | RTNPLACE (State or Foreign suntry) N • C • |
| ANNE ARUNDEL MEDI | CAL CENTER | | ANNAPO | DLIS | R | ANNE . | ARUNDEL |
| MD ANNE | ARUNDEL | | NAPOLIS | TION | | | 10d. INSIDE CITY LIMITS? VES 2 NO |
| 100. STREET AND NUMBER 901 CENTERAL (11. MARITAL STATUS | CENTRAL) | | 101 | ZIP CODE | 401 | 10g. CITIZEN (| U.S.A. |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR | Z\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | If yes, sp | | IIC ORIGIN? (Specify Yen, Puerto Rican, stc.) | 8 | ACE — American Indian, lieck, White, etc. |
| 15. DECEDENT'S EDI (Specilly only highest grad Elementary/Secondary (0-12) 1 2 17. FATHER'S NAME (First, Middle, Last) | College (1-4 or 5+) | (Give kind o | T'S USUAL OCCUPATION Work done during more retired.) | | | JSINESS/INDUSTF | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTNER'S NA | ME (First, Middle, Meider | n Surname) | |
| JAMES EDWA | RD GRISSOM | 19b. MAILU | NG ADDRESS (Street a | CALIFO | RNIA SNE | 4.44 | 1 |
| THOMAS PARKER J | R. | | 2.000 | O E. | tota various, ony or to | , otale, 249 0000 | |
| 2013METNOD OF DISPOSITION 10 Surial 2 Cremation 3 Ren 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI | noval from State ce | metery, crematory of | | | - 94 CRO | | E. MD. A.A.C |
| CHARLES E. HI | CKS 111 | | HOUSE | OF HICKS | F. SER. | NNAPOLI. 1922 FO | S, MD. 21401 REST DRIVE |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS DUE TO (OR AS | A CONSEQUENCE A CONSEQUENCE | OF): | ROSIS | | | 4 month |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH | |) cubate | g in the underlying & Hype | for . a. | Part I. 24a. WAS AI PERFO | RMED? | 24b. WERE AUTOPSY FINDING: AMBICABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER: | ACE OF DEATH (Ch | ack only one) | | |
| 1 YES 2 NO 27. MANNER OF DEATH | 1 Inpatient 2 ER/Our 26a. DATE OF INJURY | 28b. 1 | TIME OF 28c. INJ | URY AT | 6 Other (Specify) 28d. DESCRIBE HOW | INJURY OCCURE | |
| 1 Netural 5 Pending 2 Accident Investigation | (Month, Day, Year) | | M 1 🗆 ' | PIK? (ES 2 NO | | | |
| 3 Suicide 6 Could not be 4 Homicide detarmined | 26a. PLACE OF INJUR building, etc. (Sp. | Y — At home, fam ec/fy) | n, street, factory, offic | | 28f. LOCATION (Street City or Town, State | | rel Route Number, |
| | SICIAN: To the best of my kno- ER: On the basis of examinati | | | | | | se(a) and manner as stated. |
| 3 Surcios 6 Could not be 4 Homicide 6 Could not be 6 | Bedire | L-S | Print) | 28c LICENSE NUI | 488 | P P | NED (Month, Day, Year) |
| W.E.BEHRENS 2568 | | | IS, MD. 2 | 1401 | | | |
| 31. DATE FILED (Month, Day, Year) AUG 26 19 | 32. REGISTRAR'S SIG | NATURE RANGE | 4 | | -11 | | |



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| fler this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should | £ | |
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| | B.K.S | | | | | | | | | | | 94 | . 2 | 6262 | - |
|---|---|--------------------------|--|--------------------|------------------|---|----------------|---------------|------------|--------------------------------|----------------------|--------------|------------|------------------------------------|--------------|
| | 1 - FOR STATE REGISTRAR | | STATE OF I | MARYLAND (| DEPAR | | | | | MENTA | L HYGIEN | | | | |
| | 1. DECEDENT'S NAME (First | t, Middle, Last) | | | | | | | | | OF DEATH | | | 3. TIME OF DEA | TH |
| | JOSEPH | | FDANI | LIN QUA | A DE | TTT | | | | MONT | | AY | YEAR | | - 44 |
| | 4. SOCIAL SECURITY NUM | IBER | 5. SEX | 6. AGE (In yrs. Ia | | IF UNDER | 1 VEAD | IF UNDER | 24 MDC | AUC | OF BIRTH | 6 | 94 | 1PLACE (State or F | A |
| | 216-17-7453 | 3 | 1 📆 M 2 🗆 F | 19 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, Day, Year) Dec 8, 1974 | | | Countr | ry) | oreign |
| 1 | | | | 19 | ins. | لــــــــــــــــــــــــــــــــــــــ | | | | | 8, 19 | 1/4 | Ma | ryland | |
| DIRECTOR | 90. FACILITY NAME (II not PRINCE G | EORGES | | TAL CE | NTER | | | ERLY | ON OF DE | ATH | | 1 | NCE | GEORGI | ES |
| 5 | RESIDENCE OF DE | 10b, COUNT | | | 1 | | | | | | | | | | |
| E | | | | | i | Y, TOWN O | | TION | | | | | | 10d. INSIDE CIT LIMITS? | Υ |
| | Maryland | | Mary's | | CI | apti | .CO | | | | | | | 1 YES 2 🔀 | NO |
| FUNERAL | 10e. STREET AND NUMBER | | | | | | | . ZIP COD | | | | 10g. CIT | ZEN OF V | WHAT COUNTRY? | |
| H | Box 89 Hw | rry Dyr | nard ROad | i | | | 2 | 20621 | L | | | J | J.S.A | A. | |
| Z | 11. MARITAL STATUS | | 12. WAS DECEDEN | IT EVER IN U.S. A | RMED | 13. \ | MAS DEC | ENDENT O | OF HISPAN | IIC ORIGIN | i? (Specify Ye | s or No- | 14 BACE | F - American Ind | lan |
| I II | 1 Never Married 2 | Married | FORCES? 1 | YES 2 X | | 1 | f yes, sp | ecify Cube | m, Maxicar | n, Puarto | Rican, atc.) | 01 110- | | E — American Ind k, White, atc. | 14071, |
| ₽ | 3 Widowed 4 Div | orced | IF YES, GIVE V | MAR OR DATES | | 1 | YES | 2 X NO | Specify | ,. | | | Speci | | |
| | 15. DE | CEDENT'S EDU | CATION | 160 0 | ECEDENT'S | LISUAL OF | CHIDATIC | OM . | | 1 405 | KIND OF BU | 001500.00 | | White | |
| 1 📙 | (Specify or | nly highest grade | completed) | (0 | Give kind of u | vork done o | during mo | st of working | ng | 160 | KIND OF BU | SINESS/INI | JUSTRY | | |
| 1 5 | Elementary/Secondary | (0-12) | College (1-4 or 5 | +) | Servi | | | | | 7 | Tootin | ~ C 7 | in c | Condition | nina |
| g \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | | | | | Set A1 | ce i | ECIII | ILCT | 111 | I | leatin | y a F | ,11 (| Condition | птпд |
| COMPLETED | 17. FATHER'S NAME (First, I | | _ | | | | | 16. MOT | HER'S NAI | ME (First, I | Middle, Maiden | Sumame) | | | |
| BE | Joseph F. (| Quade, | Jr. | | | | | Rh | onda | l | Kaye | е | Za | mpini | |
| | 19a. INFORMANT'S NAME | Type/Print) | | 19 | b. MAILING | ADORESS | (Street a | | | | ber, City or Tox | | | | |
| 2 | Joseph F. (| Duade. | Jr. | | ox 89 | | | | | | Chapti | | | 20621 | |
| 5 | | | | 20b.PLACE | | | | | | - | | | | | |
| 2 | 20a, METHOD OF DISPOSI 1 X Burial 2 Cremati | | oval from State | | | | | | ona | | | - NOITAC | | , Maryla | 5ac |
| | 4 Donation 5 Othe | | | _ Glari | es m | _ | | | | | 94 Lec | mara | LOWII | , Mar Are | DITE |
| | 21. SIGNATURE OF FUNER | AL SERVICE LIC | CENSES / | 1 | | 22, I | HAME AN | AD ADORE | SS OF FAC | Cdine | or Fun | oral | Home | e, P.A. | |
| i ya | Much | nelo | 100 | 2006 | 10 | 1 | | | | | | | | | CEO |
| | 23. PART Finter the | | 1772 | neres | un | P. | O. I | 30X 2 | 2/0, | Leoi | nardto | wn, r | aryl | | 650 |
| | shock, or I | neart failura. | complications the List only one cau | use on each iin: | Beth. Do r B. | ot enter | the mo | de of dy | ing, such | n ss csrc | diac or resp | iretory an | rest, | Approxim | |
| 5 | IMMEDIATE CAUSE (FI | | no | | 1 | | | | | | | | | Onsat sn | |
| Ē. [| disease or condition resulting in death) | \rightarrow | - Mu | Etisch | Juna | 1110- | | | | | | | | | |
| | resulting in death) | • | OUE TO | (OR AS A CONSE | OUENCE O | F): | | | | | | | | | |
| - 6 | | | | | | | | | | | | | | İ | |
| ERTIFICATION | Sequentially list condi | | b. OUE TO | (OR AS A CONSE | OUENCE O | า: | | | | | | | | <u> </u> | |
| A | if any, leading to imme cause. Enter UNDERLY | | | | | , | | | | | | | | j | |
| | CAUSE (Diseese or in) | | c. | (OR AS A CONSE | OUTNOT OF | n. | | _ | | | | | | | |
| | that initiated events resulting in deeth) LAS | ST. | DOE 10 | (OR AS A CONSE | OUENCE U | -): | | | | | | | | i | |
| | l deding in deding Ext | | d | | | | | | | | | | | | |
| S O | PART II. Other signific | ent condition | s contributing to | death but not | recuitles | n the un | dodulos | | mluum to l | Daint 4 | | | | | il terrories |
| MEDICAL | | on condition | | destil but liot | resulting | III LINE UII | deriyiriç | g ceuse i | given in | Part I. | 24a. WAS AN PERFO | | 246. | WERE AUTOPSY I | TO |
| 1 8 | | | | | | | | | | | 1 DEYES | 2 NO | | COMPLETION OF OF DEATH? | CAUSE |
| | | | | | | | | | | | , | | | YES 2 | NO |
| | DID TOBACCO L | JSE CONT | RIBUTE TO CA | USE OF DEA | ATH YE | S 🗆 N | NO F | LINC | ERTAIN | ī | | | | 700 | |
| PHYSICIAN: | 25. WAS CASE REFERRED | | 1 | | CE OF DEAT | | | 3 0140 | EKIAII | 1 | | | | | |
| 2 | EXAMINER? | | HOSPITAL: | | | OTHER | t: | | (22,000 | | | | | | |
| s ≥ | XXYES 2 NO | | 1 inpatient 2X | | 1 | | | e 5 🗆 Re | esidence | | | | | | |
| E E | 27. MANNER OF OEATH | (i) . (ii) | 26e. OATE OF (Month, O | | 26b. TIM INJ | E OF URY | 26c. INJ WO | URY AT | . | | CRIBE HOW | | | 1. 1 | |
| B | 1 Natural 5 2 Accident | Pending investigation | 8-6 | -94 | 435 | AM | 1 🗌 1 | YES 2 | NO | 120 | for veh | uth e | 20016 | dent | |
| 28s. PLACE OF INSTANCE A COURT NOT be 28s. PLACE OF INSTANCE OF SOCIAL SECTION (Street and Number or Rural Route Court Number Court Number or Rural Route Court Number or Rural Route Court Number or Rural Route Court Number or Rural Route Court Number or Rural Route Court Number or Rural Route Court Number or Rural Route Court Number or Rural Route Court Number or Rural Route Court Number or Rural Route Court Number or Rural Route Court Number Or Rural Route Court Number or Rural Route Court Number Or | | | | | | | | | | | | | | | |
| | | | | | | | | B+ 5 | - | 4 488 | | | | | |
| | | | | | | | | 11 | | | | | | | |
| | | | | | | | | | | | | | | | |
| | 2 A. PAMET | AL EXAMINE | On the basis of a | xamination and/or | investigatio | n, in my o | pinion, d | eath occur | red at the | time, deta | and place, as | nd due to th | ie cause(a | i) and manner ee | stated. |
| ЕШ | 29b. SIGNATURE AND TITL | OF CENTIFIE | 1 11 | 7871 | | | | 29c. LICI | ENSE NUM | IBER | | 29d. DAT | E SIGNEO | (Month, Day, Year) | |
| 2 0 | 61 | enn | . 1 Ch | ute 110 | | | | 0.0 | .M. | E | | PAT | IG. | 07,199 | 4 |
| 12 | 30. NAME AND ADDRESS C | | | SE OF DEATH (ITE | M 27) (Type | Print) | | | | | | 110 | J. | 01,100 | -1 |
| | Dennis J. (| Chute, | M.D. | | | | tre | et. | Ral | t im | are. | Mare | rlan | d 2120 | 1 |

32. BEGISTRAR'S SIGNATURE
Jalia Davilson Ross 1.11.

31. DATE FILED (Month, Oby. Year) AUG 08 1994

Penn Street, Baltimore, Maryland 21201

| BALTIMORE, MARYLAND 21215-0020 | OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physici |
|---|---|
| | nours after de |
| • | |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | . OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with |
| RECORD. | w requires that the |
| OF VITAL | PHYSICIAN: The la |
| DIVISION | OR ATTENDING F |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Thours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - STATE REGISTRAR | STATE OF MARYL | | TMENT OF H | | MENTAL | HYGIENE REG. NO. | | | | |
|--------------|--|---|---|---|---|---------------|---------------------------------|--------------|---|--|---------|
| | 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH MONTH DAY YEAR | | | | | | | | 3. TIME OF DEA | ATH | |
| | ROBERT ELWOOD ROB | IF UNDER 24 HRS. | 08 24 94 | | | 4:45 | Рм | | | | |
| | 214 05 7884 | 1 🗶 M 2 🗆 F | (In yrs. last birthday) 80 YRS. | 7. DATE OF BIRTH (Month, Day, Year) Jan. 26,1914 6. BIRTHPLACE (State or Fore Country) Md. | | | | | Foreign | | |
| CH | 99. FACILITY NAME (If not institution, give s SACRED HEART HOS | | | CUMBER | LAND | DEATH | | 9c. COUNTY | | | |
| DIRECTOR | 10a. STATE 10b. COUNT Md . A1 | v legany | 10c. CIT | Y, TOWN OR LOCA | | /ale | | | 10d. INSIDE CITY LIMITS? 1 YES 2 KNO | | |
| A | 10e. STREET AND NUMBER | | | 10 | . ZIP COOE | | | 10g. CITIZEN | OF W | HAT COUNTRY? | |
| FUNERAL | 430 Natio | | | | 21502 | | | | .S. | Α. | |
| B | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D | 2 NO | If yes, sp | ENOENT OF HISPA ecity Cuben, Mexic 2 NO Speci | en, Puarto Ri | | or No— 14. | Black Specifi | — American ind i, White, etc. fy: White | dien, |
| ETED | 15. OECEOENT'S EOU (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5+) | 16a, OECEOENT'S (Give kind of ville. Do NOT us | USUAL OCCUPATION Work done during mose retired.) | ON ist of working | 16b. (| KIND OF BUS | INESS/INOUS | TRY | | |
| COMPLET | 12 | | Busi | ness/Ret | ail | | Liquo | r/Mote | 1 | | |
| - | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S N | | | | | | |
| BE | Maurice Ea | rl Robinet | | AODBESS (Charles | LO1 | | ae Las | | | | |
| 2 | R. Roger Robinett | e | | | | | | | 00) | | |
| | R. Roger Robinette 440 National Hwy. LaVale, Md. 21502 200. METHOD OF OISPOSITION 1 Burlai 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) The Cumberland Crematory 8/25/94 Cumberland, Md. | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | e Cumber. | | NO ADDRESS OF FA | | 4 Culli | Jerran | .u , | riu. | |
| à | + Kelent (| Colema | 1 | | ritt-Ada | | | | | | |
| | 23. PART i. Enter the diseeses, or | complications that cause | d the death. Do n | ot enter the mo | Decatured of dying, such | ch ss cerdi | Cumb. | atory srrest | | Approxir | nats |
| | shock, Dr heert fellure. List only Dne ceuse Dn esch line. IMMEDIATE CAUSE (Final disease or condition resulting in desth) S. OUE TO (OR AS A CONSEQUENCE OF): Shock Dr heert fellure. List only Dne ceuse Dn esch line. Interval Betwee Onset and Des Ons | | | | | | | | | | |
| TION | Sequentially list conditions, Out TO (OR AS A CONSEQUENCE OF): 15 you Out TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| ERTIFICATION | Cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in deeth) LAST d. | | | | | | | | | | |
| MEDICAL CE | PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. Unity performed? 1 YES 2 NO | | | | | | | | WERE AUTOPSY AWAILABLE PRIOR COMPLETION OF OF GEATH? | R TO | |
| | 212 702 600 1107 | | | | | | | | | 1 YES 2 | NO |
| AN | DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL | CONTRIBUTE TO | CAUSE OF | | ACE OF DEATH (C) | ME | | | L | | |
| 3 | EXAMINER? | HOSPITAL: | patient 3 DOA | OTHER: | e 5 🗆 Residence | | | | | | |
| PHTSICIAN: | 27. MANNER OF OEATH | 26e. OATE OF INJURY (Month, Day, Year) | 28b. TIM | E OF 26c. INJ | | 1 | RIBE HOW IN | JURY OCCUR | EO | | |
| 2 | 1 Natural 5 Pending 2 Accident Investigation | (| | | YES 2 NO | | | | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined 28e. PLACE OF INJURY — At home, tarm, streat, factory, office building, etc. (Specify) | | | | | | TION (Street er Town, Stete) | nd Number or | Aural A | loute Number, | |
| COMPLEIED | | ICIAN: To the best of my know | | | | | | | euse(e) |) and manner ee | stated. |
| | 296. SIGNATURE AND TITLE OF CERTIFIE | 5 | | | 29c. LICENSE NU | IMBER | T | 29d. DATE SI | GNEO | (Month, Day, Year | r) |
| | Lene 1 | Sry MO | | | D125 | 32 | | 1 8 | - 2 | 25-94 | 0 |
| - | DR. GEORGE BREZA | | | | BERLAND, | MD 2 | 1502 | · | - | - | |
| | 31. DATE FILEO (MONTH, Day 1994 | 37. REGIZHARE SIGN | | | | | | | | | |

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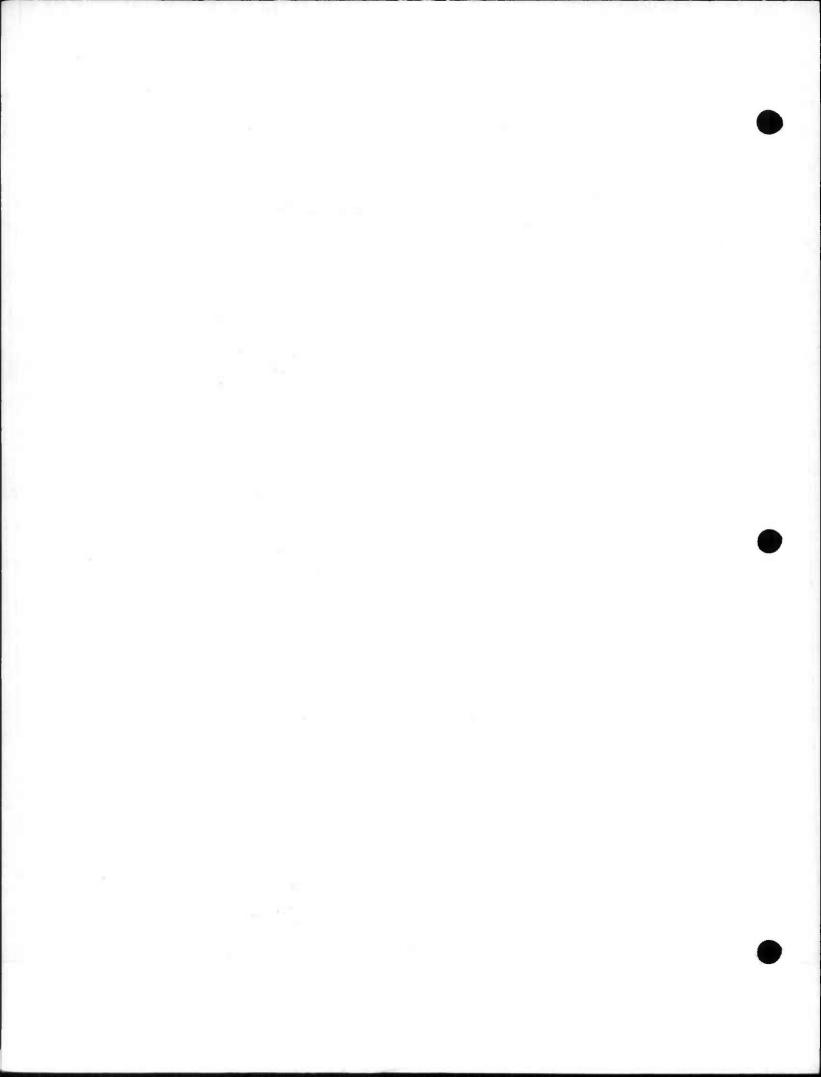
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| FOR | | | | | | | | | 9 | 4 | 2020 | 4 | |
|--|---|---|---------------------------------|------------------------------------|---|----------------------|---------------|-------------------|---------------|---------------------|-------------------|-----------------|--|
| 1 - STATE REGISTRAR | | STATE OF N | | | RIMENT OF I | HEALTH AND | MENTAL | REG. N | | | | | |
| 1. DECEDENT'S NAME (F) | st, Middle, Last) | | | **- | | | | OF DEATH | | | 3. TIME OF OE | ATH | |
| RICHARD | | ELWOOD | | | RAYNE | | ATIG | 17, | 1994 | YEAR | 315 | A M | |
| 4. SOCIAL SECURITY NU | MBER | 5. SEX | 6. AGE (In yrs. | last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE O | OF BIRTH | 1777 | 8. BIRT | HPLACE (State or | Foreign | |
| 216-09-5919 | | 1 📉 M 2 🗆 F | 74 | YRS. | MONTHS DAYS | HOURS MIN. | AUG. | 20, | 1919 | Count | YLAND | | |
| 9e. FACILITY NAME (If no | institution, give s | treet and number) | | | 9b. CITY, TOWN | OR LOCATION OF | _ | | | INTY OF I | DEATH | | |
| 105 CEDAR A RESIDENCE OF DE 10e. STATE MARYLAND | | | | | BERLIN | | | | WOR | CEST | ER | | |
| RESIDENCE OF DE | 10b. COUNT | 1 | | 10c, CIT | Y, TOWN OR LOCA | TION | | | - | | 10d. INSIDE CI | TV | |
| MARYLAND | WOR | CESTER | | R | ERLIN | | | | | | LIMITS? | | |
| | | OLDILK | | D. | | f. ZIP CODE | | | 10a, CI | IZEN OF | WHAT COUNTRY | | |
| 100. STREET AND NUMBER 105 CEDAR A 11. MARITAL STATUS | VENIIE | | | | | 21811 | | | | USA | | | |
| 11. MARITAL STATUS | VVLINOL | 12. WAS DECEDEN | T EVER IN U.S. | ARMED | 13. WAS DE | CENDENT OF HISPA | NIC OBIGIN | 7 (Specify V | na or No | | E — American In | dlan | |
| | _ | | YES 2 | | If yes, s | ecify Cuban, Mexic | an, Puerlo R | ican, etc.) | - OI IVO | Blac | ck, White, atc. | aren, | |
| 3 Widowed 4 D | vorced | WW II | AN ON OAILS | | 1 1 16 | 2 A NO Speci | my: | | | Spec | WHITE | | |
| 15. D | CEDENT'S EDU | | 16a. I | DECEDENT'S | USUAL OCCUPATI | ON | 16b. | KINO OF B | USINESS/IN | OUSTRY | | | |
| Elementary/Secondary | | College (1-4 or 5 a | | (Give kind of a life. Do NOT us | work done during m se retired.) | ost of working | | | | | | | |
| 4 | 2 | | | R | ETAILER | | | FOO | D | | | | |
| 15. D (Specify of Spec | Middle, Last) | | | | | 18. MOTHER'S N. | AME (First, M | fiddle, Maide | n Sumame) | | | | |
| EDGAR L. RA | YNE | | | | | IDA HAS | STINGS | 3 | | | | | |
| | (Type/Print) | | | 19b. MAILING | ADDRESS (Street | and Number or Rural | Route Numb | er, City or To | wn, State, Zi | ip Code) | | | |
| DONA M. RAY | NE | | | 105 C | EDAR AVE | NUE, BEI | RLIN. | MARY | LAND | 218 | 11 | | |
| 20a. METHOD OF DISPOS | 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State | | | | | | | | | | | | |
| | 4 Donation 5 Dother (Specify) EVERGREEN CEMETERY 8/20/94 BERLIN, MARYLAND | | | | | | | | | | | | |
| 21. SIGNATURE OF FUNE | IAL SERVICE LIC | ENSEE | 1 1 1 | | | NO ADDRESS OF F | | 7 . | 2211 | | | | |
| 11/ | 11 /11 | 25 | 1 | | | | | | | | | | |
| yun | es w | 0 Jack | / | | | NGS FUNI | | | | | LE, DE. | 1997 | |
| 23. PART I. Enter the ehock, or | 23. PART I. Enter the disease, or complications that caused the de- ehock, or heart failure. List only one cause on each line. | | | | not enter tha me | ode of dying, su | ch as card | lac or ree | piratory a | reet, | Approxi | mate Between | |
| IMMEDIATE CAUSE (I | insi | 112.500 | | | | | • | | | , | Onset a | nd Death | |
| disease or condition resulting in death) | \rightarrow | . un | DUE TO GOT AS A CONSEQUENCE OF: | | | | | | 5 | | | | |
| | resulting In death) e. ung Cames with Umphangitic Multisters | | | | | | | | | | fpri l | 1990 | |
| Z Segmentially list con- | | | | | | | | | | | | | |
| if any, leeding to Imn | Sequentially list conditione, Due TO (OF AS A CONSEQUENCE OF) | | | | | | | | | | | | |
| CAUSE (Disease or In | | co | ona | ry ? | SCH | emo | _ | | • | | | | |
| thet initiated events | | DUE TO | (OR AS A CONS | SEOUENCE O | F): | | | | | | | | |
| ш I resulting in death) С | 31 | d | | | | | | | | | | | |
| . PART II Other elevidi | cent condition | s contributing to | deeth but no | t resulting | in the underlyin | a ceuse alven la | Part i | 24a WMS A | N AUTOPSY | 24 | b. WERE AUTOPSY | EINDINGS | |
| DID TOBAC 25. WAS CASE REFERRED EXAMINER? 1 YES 2 P NO 27. MANNER OF DEATH | | | | | | g co-co giron ii | | | DRMEO? | , ``` | AVAILABLE PRIO | R TO | |
| | | | | | | | — 1 | 1 TYES | 2 NO | | OF DEATH? | CHUSE | |
| Σ | | | | | | | _ | | | | 1 YES 2 | NO | |
| DID TOBAC | | CONTRIBUT | E TO CA | USE O | | | | | | | | | |
| 25. WAS CASE REFERRED EXAMINER? | TO MEDICAL | HOSPITAL: | | | 26. P | LACE OF DEATH (C | heck only one | 9) | | | | | |
| YES 2 NO | | 1 Inpatient 2 | | | 4 - Nursing Hor | ne 5 Residence | | | | | | | |
| 27. MANNER OF DEATH | Bendine | 28a. DATE OF (Month, D | | 28b. TIM | JURY W | JURY AT ORK? | 28d. OE\$ | CRIBE HOW | INJURY O | CURED | | | |
| 1 Waturel 6 | III I P RELUCII D Pengine | | | | | | | | | | | | |
| III I MARKUTIII 2 | meetigation | 2 Dulate — 1 288, PLACE OF INJURY — At home farm street factory office 1 281 LOCATION (Street and Mumber or Durat S | | | | | | | | Route Number. | | | |
| 2 Accident | Could not be | | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | Uny o | W POWER, Start | (e) | | | | |
| 2 Accident | 1 | | | | | | City o | WIN JUNETI, State | (9) | | | | |
| 2 Accident | Could not be determined | building, | stc. (Specify) | death occurr | | end place, end du | | | | | | | |
| 2 Accident | Could not be determined | cian: To the best of | stc. (Specify) my knowledge, | | ed at the time, dat | | e to the cour | ee(a) and m | enner ee str | sted. | | stated. | |
| 2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only one) 2 Miles | Could not be determined RTIFYING PHYSI DICAL EXAMINE | CIAN: To the best of R: On the bests of e: | stc. (Specify) my knowledge, | | ed at the time, dat | death occured at the | e to the ceue | ee(a) and m | enner ee str | sted. the cause(| (e) and manner ea | | |
| 2 _ Accident 3 _ Suicide 4 _ Homicide 29e. CERTIFIER (Check only one) 2 _ ME | Could not be determined RTIFYING PHYSI DICAL EXAMINE | CIAN: To the best of R: On the bests of e: | stc. (Specify) my knowledge, | | ed at the time, dat | | e to the ceue | ee(a) and m | enner ee str | sted. the cause(| | | |

ATURE AND TITLE OF CERTIFIER H4361 WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) SCOTT SWEENE BETLIN 10507 ROAD 21811 FRIENDSHIP 31. DATE FILED (Month, Day, Year) AUG 1 9 1994 32. DEGISTRAR'S SIGNATURE Julia D'aurelien-Randall



BALTIMORE, MARYLAND 21215-0020

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| HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing noons after death. Page 6 may be retained by the hospital or attending physician. | FAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should | I Mental Hygiene prior to burial, crem | DODIANT History Of In mending on the second interest or attact the mending around the median at another |
|--|--|--|---|
| HOSPITA | FUNERAL DI | within 72 | PTAMT. 10 |
| HE C | 出口 | filed | JUDI |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | | NT OF HEALTH AND I | MENTAL HYGIENE REG. NO. | | | | | |
|----------------------|--|--|---|---|---|---|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | SR | EID | Jr. | 2. DATE OF DEATH MONTH DAY | 3. TIME OF DEATH 5.44-PM | | | | |
| | 217-16-9310 | 1 1 M 2 F | yrs. lest birthdey) IF UN MONTH | DER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH (Morth, Day, Year) Jan 29, 19= | 8. BIRTHPLACE (State or Foreign Country) | | | | |
| STOR | 9a. FACILITY NAME (If not institution, give stre SOOC Saman to RESIDENCE OF DECEDENT | Lho inte | l 96.0 | Ballmore Ballmore | EATH | Baltimore | | | | |
| DIRECTOR | 10e. STATE 10b. COUNTY | icómico | 10c. CITY, TOW | hor Location lists ury | | 10d. INSIDE CITY LIMITOY 1 A YES 2 NO | | | | |
| FUNERAL | 308 Billing Vis | ta Auc. | | 101. ZIP CODE | 801 | IOG. CITIZEN OF WHAT COUNTRY? | | | | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 DWorced | 12. WAS DECEDENT EVER IN FORCES? 1 TES IF YES, GIVE WAR OR DAT | 2 NO | I3. WAS DECENDENT OF HISPAN If yes, specify Cuber Moxica 1 YES 2 NO Specify | n, Puerto Rican, etc.) | No— 14. RACE — American Indian, Black, White, stc. Specify: | | | | |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade or Elementary/Secondary (0-12) | | 16a. DECEDENT'S USUAL (Give kind of work do life. Do NOT use relige | ne during most of working d.) | 16b. KIND OF BUSIN | ESS/INDUSTRY | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) James M. | Reid | Sc | 18. MOTHER'S NA | ME (First, Middle, Malden Sui | magne) | | | | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) EUNITE G. | Jahnson | 11111 | ESS (Street and Number or Aural I) | | | | | | |
| | 20q. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remov 4 Donation 5 Other (Specify) | al from State 20b. 8 cegge | PLACE AND DATE OF DISK terry crematory or other pla S KIN S A GREEN | cost Cime fary | DATE 20c. LOCATE | TION - City or Town, State | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | THEE . | | LEWIS NO. | FRd. So | alis bury nd. | | | | |
| | 23. PART I. Enter tha diseases, or co- ahock, or heart failure. Use IMMEDIATE CAUSE (Final disease or condition resulting in death) | st Dnly Dne cause Dn ead | TASTA | ter the mode of dying, such | | Interval Between | | | | |
| CERTIFICATION | Sequentially flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other algnificant conditions | contributing to death bu | t not reaulting in the | underlying cause given in | Part I. 24s. WAS AN AU PERFORME 1 U YES 2 | ED? AVAILABLE PRIOR TO | | | | |
| SICIAN | | HOSPITAL: | Name 3 DOA 4 D | 28. PLACE OF DEATH (Chi | | | | | | |
| ВУ РНУ | 27. MANNER OF DEATH 1 Natural 5 Pending Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW INJU | JRY OCCURED | | | | |
| | 3 Suicide 8 Could not be 4 Homicide detarmined | 28s. PLACE OF INJURY - building, etc. (Specif | At home, term, street, t | ectory, office | 281. LOCATION (Street and City or Town, State) | Number or Rural Route Number, | | | | |
| COMPLETED | | | | e time, data and place, end dua ry opinion, death occured at the | | r sa stated. Jue to the cause(s) end menner sa stated. | | | | |
| TO BE C | 29b. SIGNATURE AND TITLE OF CERTIFIE | 400 | MS | P - C | 6723 2 | 9d. DATE SIGNED (Month, Day, Year) AUG, 16, 1999 | | | | |
| F | 30. NAME AND ADDRESS AF PERSON WHO 31. DATE FILED (Month, Day, Year) | 1000 | 601 400 | # RAVEN | BLVS | 21239. | | | | |
| | AUG 1 8 1994 | 32. REGISTRAR'S SIGNAT | on-Randall | | | | | | | |

AL BEN 1994 ALA 1000

31. DATE FILED (Month) Day Year)

July 22. REGISTRANS SIGNATURE

A STATE FILED (Month) Day Year)

| DIVISION OF VITAL RECORDS, P.O. BOX 68760. | BALTIMORE, MARYLAND 21215-0020 |
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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with rouns after death. Page 6 may be retained by the hospital or after the physician physician of the hospital or after the physician physician of the hospital or after the physician physician of the hospital or after the physician of the hospital or after the physician of the hospital or after the physician of the hospital or after the physician of the hospital or after the physician of the hospital or after the physician of the hospital or after the physician of the hospital or after the physician of the hospital or after the physician of the hospital or after the physician of the hospital or after the physician of the hospital or after the physician of the physic | ours after death. Page 6 may be retained by the hospital or attending physician |
| TO THE FUNERAL DIRECTOR: After this carlificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burner training the property of the filled within 72 hours after death with the State Dent, of Health and Mental Horiene order to burlal, cremation, or removal. | is in by the funeral director, page 5 should be detached for use as the burner from the contract of 2, 3 should by removal. |
| IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | medical examiner must be notified at once. |

| | FOR 1 - STATE | STATE OF M | | | | | | | MENTAL | | | | | |
|--------------------|---|---|--------------------|---------------------------|---|------------|--------------------|-----------|--------------------------------|-----------------|--------------|------------|--|--|
| 15 | REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) | - | C | ERTIF | ICAT | E UF | DEAL | Н | T - 2475 0 | REG. NO | | | | |
| - 8 | ANDREW JOHN HO | אדת שוני | 77 | | | | | | 2. DATE O | D | AY | YEAR | 3. TIME OF DEATH | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. Ia | na hilata da d | | R 1 YEAR | IF UNDER | | Augus | | 199 | - | 23:55 M | |
| | | 1 ☑ M 2 ☐ F | 50 | , , | MONTHS | DAYS | HOURS | MIN. | 7. DATE Of (Month, | Day, Year) | | B. BIRTH | PLACE (State or Foreign y) | |
| . 8 | 212-32-2134 | 2 1 2 - 3 2 - 2 1 3 4 | | | | | | | June 1, 1935 Marylar | | | | | |
| Œ | | | | | | | R LOCATIO | | | | 9c. COU | YTY OF DI | EATH | |
| DIRECTOR | Carroll County | Genera. | l Hosp | <u>ital</u> | W | esti | nins | ter | | | | Carr | :011 | |
| DE C | 10e. STATE 10b. COUNTY | | | 10c. CIT | Y, TOWN | OR LOCAT | ION | | | | - | | 10d. INSIDE CITY | |
| P | Maryland Bal | timore | | 0.70 | rince | c M | ills | | | | | | LIMITS? | |
| AL | 10e. STREET AND NUMBER | 01111010 | | | T 110 | | ZIP CODE | | | | 10g. CITI | ZEN OF W | THAT COUNTRY? | |
| FUNERAL | 9415 Owings Hei | ahts C | ircle | Apt 102 21117 | | | | | | | IIni | tod. | States | |
| S | | 12. WAS DECEDENT | EVER IN U.S. AF | RMED | | WAS DEC | ENDENT O | F HISPAI | NIC ORIGIN? | (Specify Yes | or No- | 14. RACE | - American Indian, | |
| | 1 Never Married 2 N Merried | IF YES, GIVE W | | NO | 1 yes, specify Cuban, Mexica 1 YES 2X NO Specify | | | | , Mexican, Puerio Rican, etc.) | | | | 4. RACE — American Indien, Black, White, etc. Specify: | |
| ВУ | 3 Widowed 4 Divorced | 1958- | 1964 | | | | | | | | | | White | |
| COMPLETED | ts. DECEDENT'S EDUCA (Specify only highest grade of | | (6 | ECEDENT'S Sive kind of | work done | durina mo | ON st of workin | g | 16b. K | IND OF BU | SINESS/IND | USTRY | | |
| E | Elementary/Secondery (0-12) | College (1-4 or 5+ |) Hife | Do NOT u | , | | | | | | | | | |
| MP | | 3 | | Sa | les | | | | | | ompu | ters | 5 | |
| | 17. FATHER'S NAME (First, Middle, Last) | 14 | | | | | - | | AME (First, Mic | | , | | | |
| BE | Andrew Damron R | cice | | | | | | _ | a Est | | | | ower | |
| 2 | Edith F. Rice | | | | | | | | Route Number | | | | 21117 | |
| | | prize owings heights effect, owings wills | | | | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION SCI Burlet 2 Cremetton 3 Removal from State 20b. PLACE AND DATE Of DISPOSITION (Name of Cemetery, cremetory or other place) Westminster Cemetery 8/27 Westminster, MD | | | | | | | | | | | | | |
| 17 | 4 ☐ Donation 6 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE | MOEE | West | mins | ter | Cer | nete | ry | 8/2 | 7 Wes | stmi | nste | er, MD | |
| | A South one or Forence Service Lice | 1.11- | 15N | | | | | | al Ho | nm _O | | | 4 | |
| | Cull on to | Lane | tyTh | ulk | 2 9 | 1 W | 111 | SS | t. We | s+m | inst | er. | MD 21157 | |
| | 23. PART I. Enter the diseases, or co shock, or heart failure. L | emplications that | caused the de | inth. Do | not ente | r the mo | de of dyl | ng, suc | h as cardis | c or resp | iratory arr | est, | Approximate | |
| | IMMEDIATE CAUSE (Final | | | 1.1 | | | | | | | | | Onset and Death | |
| | disease or condition reaulting in death) | . Pa | nrile | ITX | lin | | | | | | | | 17 doin | |
| | | DUE TO | OR AS A CONSE | OUENCE O | F): | A.A | 1 1 | 1 | | | | | 11/ | |
| Z | Sequentially list conditions, b. | lung | Lov | nce | 1 - | Me | Town | the | | | | | 1/km | |
| TIC | If any, leading to immediate | DUE TO | OR AS A CONSE | QUENCE O | F): | | | | | | | | 0 | |
| 2 | CAUSE (Disease or Injury | | | | | | | | | | | | | |
| CERTIFICATION | that initiated events reaulting in death) LAST | DUE TO | OR AS A CONSE | OUENCE O | F): | | | | | | | | | |
| ER | d. | | | | | | | | | | | | | |
| | PART II. Other significant conditions | contributing to | death but not | reaulting | In the u | nderlyln | cause o | Ivan In | Part I. 2 | 4s. WAS AN | AUTOPSY | 24b. | WERE AUTOPSY FINDINGS | |
| PHYSICIAN: MEDICAL | | | | | | | | | | PERFOR | | | AVAILABLE PRIOR TO COMPLETION DF CAUSE | |
| | | | | | | | | | | YES 2 | DO NO | | OF DEATH? | |
| 2 | | | | | | | | | _ | | | | 1 YES 2 XNO | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | | | 26 PI | ACE OF D | EATH (C) | neck only one) | | | | | |
| SIC | | HOSPITAL: | EB/Outpetient 3 | 3 DOA | OTHE | R: | | | | | | | | |
| Η | 27. MANNER OF DEATH | 28a. DATE OF | | 28b. TIA | | 28c. INJ | | sidence | 6 Other (| - | NJURY OC | CURED | 73174 | |
| 7 | 1 Natural 5 Pending | (Month, De | ly, Year) | | JURY | WO | RK? /ES 2 | NO | | | | DOTTED | | |
| В | 2 Accident Investigation 3 Suicide & Could not be | 26a. PLACE OF | INJURY — At he | ome, term, | street, led | | | | 281, LOCAT | ION (Street | and Number | or Rural B | loute Number. | |
| | 4 Homicide 6 Could not be | building, | etc. (Specify) | | | | | | | Town, State) | | | | |
| COMPLETED | 29e. CERTIFIER | AM. T. A | | | | | | | | | | | | |
| MP | (Check only | | | | | | | | | | | | 100000000000000000000000000000000000000 | |
| 00 | 2 MEDICAL EXAMINER | - On the basis of \$3 | armsetton and/or | investigati | ⊮n, in my | opinion, d | eath occur | ed at the | time, date a | nd place, ar | nd due to th | e ceuse(e |) end manner se stated. | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | . 115 | | | | | 29c. LICE | NSE NUI | MBER | | 29d. DAT | E SIGNED | (Month, Day, Year) | |
| | MARIONA | or lan | 1 | | | | 1): | 261 | 116 | | 7 | 5-24 | 1-94 | |
| 2 | 30. NAME AND ADDRESS DE PERSON WHO | | | | | | | - | | | | | | |

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1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO.

| | REGISTRAR | | | ERIIF | ICAIC | UF | DEA | 1 17 | REG. NO |). | | |
|-------------------|---|--|--|--------------|----------------|--|------------|--------------------------------|---|--------------------------------|--|---|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | BEDOYA R | OSSI | | | | | | 2. Date of Death Month August 26 1994 7:00 A.M. | | | |
| | 4. SOCIAL SECURITY NUMBER 578-70-8050-8030 | 5. SEX | lest birthday) YRS. | IF UNDER | t YEAR DAYS | IF UNDER | 24 HRS. | 7 DATE OF BURTH | Month, Day, Year) Cor | | IPLACE (State or Foreign | |
| 5 | 90. FACILITY NAME (If not institution, give a 1013 Radiance | 9b. CITY, | 9b. CITY, TOWN OR LOCATION OF DEATH Cambridge | | | | | 9c. COUNTY OF DEATH Dorchester | | | | |
| DIRECTOR | | 10b. COUNTY 10c. C | | | | | ion Ige | | | 10d. INSID LIMIT 1 1 YES | | |
| LONERAL | 100. STREET AND NUMBER 1013 Rad | 10f. ZIP CODE 21613 | | | | | U.S.A. | | | | | |
| | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | | | | | | | | | | | — American Indian, k, White, etc. |
| COMPLETED | (Specify only highest grade completed) (Give kind of the bind of | | | | | USUAL OCCUPATION Vork done during most of working e refered.) 16b. KIND OF BUSINESS/INDUSTRY Ophthalmologist | | | | | | ist |
| BE COM | 17. FATHER'S NAME (First, Middle, Lest) AUGUSTO | | 18. MOTHER'S NAME (First, Middle, Meiden Surneme) LILI CAMERE | | | | | | | | | |
| 108 | Dr. Humberto A. | | D ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) R Radiance Drive, Cambridge MD 21613 | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION 1 Buriel 2 A Cremetion 3 Rem 4 Donation 5 Other (Specify) | of Disposition/Name of DATE 20c. LOCATION — City or Town, State 20th Epidece matory 8/27 Salisbury Maryland 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | & Mar | ma g | 11 | | | | | Thoma., Cambri | | | |
| | 23. PART I. Enter the diseases, pr shock, pr heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) | complications the List only one can | use on each li | death. Do | not enter | the mo | de of dy | ing, suci | as cardiac or rea | piratory ar | rest, | Approximate Interval Batween Onset and Death 72 hov 5 |
| 25 | DUE TO (OR AS A CONSEQUENCE OF): OBSTRUCTURE URE PATHY DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | 72 hours | |
| NO POLICE IN LINE | | | | | | | | | | | 6Mos | |
| MEDICAL CE | PERFORMED? 1 YES 2 HO COM OF C | | | | | | | | | | . WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| HISICIAIN. | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER | t: | | / | ock only one) | | | |
| SI LLIIS | 1 YES 2 NO 1 Inpetient 2 DER/Outpetient 3 DOA 4 Nursing Home 5 Desidence 6 Other (Specify) 27. MANNER OF DEATH 286. DATE OF INJURY (Month, Day, Year) 286. DATE OF INJURY (Month, Day, Year) 1 Period | | | | | | | | | | | |
| | 2 Accident investigation 3 Suicide 6 Could not be determined 5 Unicide 6 Could not be determined 25e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 25e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) | | | | | | | | | | Route Number, | |
| COMPLETE | 29e. CERTIFIER 1 Check only one) 1 CERTIFYINO PHYS | | | | | | | | | | | e) and manner ea stated. |
| 200 | 200 SIGNATURE AND TITLE OF CERTIFIE | word | ay Mi | 3 | | | 29c, LIC | 68 | 60 | 29d. DAT | E SIGNED | (Month, pay, Year) |
| | | RANIM | D 21 | EM 27) (Type | LA. | ST. | 50 | ite | 2A CAT | UBRI | 160 | MD 21613 |
| | 31. DATE FILED (MONTH, Day, Year) AUG 2 9 1994 | | AR'S SIGNATURE | dall | | | | | | | | |



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| | BALTIMORE, MARYLAND 21215-0020 | ained | phoule | liffed |
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| | ORE | 6 тау | rtor, pa | nust t |
| | M | Page | al direc | ner n |
| | ALT | death. | funer | рхаш |
| | 8 | after | by the | lical |
| 4 | | mon. | lled in | e me |
| | ٦, (| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 Rours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buna transfit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| | 39 X | EXECT | n and to but | imati |
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| | S, P | death | e atter | ury, o |
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| | Z. | HCIAN | the S | , or |
| | DIVISION OF VITAL RECORDS, P.O. BOX 68760, | PHYS | r this | arked |
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| | NIS | R ATTE | RECTO JIS afte | ш 28 |
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| | 1 - STATE REGISTRAR | STATE OF MARYL | | TMENT OF I | | MENTAL HYGIEN | | | |
|--|---|---|--|--|--|---|----------------------------------|--|--|
| 3 | DECEDENT'S NAME (First, Middle, Last) | rank Anthony | | | | 2. DATE OF DEATH MONTH O8 | | 3. TIME OF DEATH | |
| | 4. SOCIAL SECURITY NUMBER 212-05-7022 | 5. SEX 6. AGE (| 36 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 11-3-07 | 8. Bill Co | ATHPLACE (State or Foreign untry) Jersey | |
| TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION TO BE COMPLETED BY FUNERAL I | 96. FACILITY NAME (If not institution, give str Meridian - Spa Cree | | | 96. CITY, TOWN | I OS | EATH | 9c. COUNTY OF DEATH Anne Arundel | | |
| DIRECT | residence of decedent 10a. STATE 10b. COUNTY Maryland Anne A | Arundel | | y, town on Loca Severnal F | | | | 10d. INSIDE CITY LIMITS? YES 2 NO | |
| | 100. STREET AND NUMBER 737 B& A BLVD. | | | 10 | 21146 | | U.S.A. | F WHAT COUNTRY? | |
| B≺ | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, OIVE WAR OR DA | 2 X NO | 13. WAS DEC | ENDENT OF HISPAI ecify Cuban, Mexica 2 NO Specif | NIC ORIGIN? (Specify Yes in, Puerto Rican, etc.) y: | B | ACE — American Indian, lack, White, etc. | |
| PLETED | 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) 12 | Cation completed) College (1-4 or 8 +) | (Give kind of a life. Do NOT us | USUAL OCCUPATION Work done during mole retired.) | ON est of working | 16b. KIND OF BU | | , | |
| E COM | 17. FATHER'S NAME (First, Middle, Last) Carmine Ristaino | | - | | | ME (First, Middle, Meiden ia Alvino | Sumame) | | |
| | 190. INFORMANT'S NAME (Type/Print) Isabelle Ristaino | | | | | Route Number, City or Town | | | |
| | 20e. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remo 4 Donation 5 Other (Specify) | ovel from State | PLACE AND DATE OF PLACE AND DA | s Cath C | Cem | 8-23 Anr | | Md. | |
| | 21, SIGNATURE OF FUNERAL SERVICE LICE | fullyes | | Home I | nc. 147 | Duke of GI | ouceste | Funeral r WSt. | |
| | 23. PART I. Enter the disesses, pr conshock, pr heart failure. L | omplications that caused list only one cause on ea | sch line. | · | | h as cardiac or respi | ratory srrest, | Approximate interval Between Onset and Death | |
| | disease or condition resulting in death) | DUE TO (OR AS A | CONSEQUENCE OF | mm | 14 | 0 . + | | Merlin | |
| TION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE O | Janu J | 411 | Moun | > | | |
| ERTIFICA | cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF | F): | V | | | | |
| AL | PART II. Other significant conditions | contributing to death be | ut not resulting | in the underlying | g cause given in | Part I. 24s. WAS AN PERFOR | IMED? | 4b. WERE AUTOPSY FINDINGS AMARABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| AN: N | 25. WAS CASE REFERRED TO MEDICAL | | | 26 Pi | ACE OF DEATH (Ch | nok ontv one) | | T TES 2 Z NO | |
| TYSIC | | HOSPITAL: 1 Inpatient 2 ER/Outpo | etient 3 DOA | OTHER: 4 Nursing Hom | e 5 🗆 Residence | 8 Dther (Specify) | | | |
| | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) 28a. PLACE OF INJURY | INJ | M 1 . | PRK? /ES 2 NO | 28d. DESCRIBE HOW II | | | |
| ETED | 3 Suicide 6 Could not be determined | building, etc. (Speci | ·/y) | | | 281. LOCATION (Street a City or Town, State) | | al Houte Number, | |
| OMPL | | EIAN: To the best of my knowled: On the basis of examination | | | | | | e(a) and manner as stated. | |
| BE | 29b. SIGNATURE AND THE OF CENTIFICA | Myo-10. | 610, M.J. | Lalenta | 03/188 | MBER | 29d. DATE SIGN | ED (Month, Day, Year) | |
| | 30. NAME AND JODRESS OF PERSON WHO Dr. Michael LaPenta | | | | olis , M | Md. 21401 | - | | |
| | 31. DATE FILED (Month, Day, Year) AUG 22 19 | 32. REGISTRAR'S SIGN | | | - | | | | |

Auferralised A register agent

ay be retained by the hospital or attending physician. page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| STATE OF MARYLAND | DEPARTMENT | OF HEALTH AND | MENTAL HYGIENE |
|-------------------|------------|---------------|-----------------------|
| С | ERTIFICATE | OF DEATH | BEG NO |

| | FOR 1 - STATE REGISTRAR | STATE OF MARY | | MENT OF H | | ENTAL HYGIEN | E | | | | | | |
|---------------------------------|--|---|---------------------------|---------------------------------|--|--------------------------------------|--------------------|----------------------------------|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATN | | 3. TIME OF DEATN | | | | | |
| - 9 | JACQUELYN L | ÆE | SEWALL | 1 | | August 19 | , 1994 EAR | 12:50 P m | | | | | |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH | 8. BIFF | TNPLACE (State or Foreign | | | | | |
| | 214-94-5127 9a. FACILITY NAME (If not institution, give | | 29 YRS. | | r 30, 1965 NJ | | | | | | | | |
| ٦ | Memorial Hospita | - | | Cumber | R LOCATION OF DEA | 9c. COUNTY OF DEATN Allegany | | | | | | | |
| ا ق | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | | | TOWN OR LOCAL | | | | | | | | | |
| DIRECTOR | | egany | | berland | ION | 10d. INSIDE CITY LIMITS? 1 YES 2 XNO | | | | | | | |
| | 10e. STREET AND NUMBER | egary | Can | | . ZIP CODE | | 10g. CITIZEN OF | WHAT COUNTRY? | | | | | |
| 215 East Oldtown Road 21502 USA | | | | | | | | | | | | | |
| | 11. MARITAL STATUS 1 Never Married 2 Married | IN U.S. ARMED 2 Z-NO | 13. WAS DEC | ENDENT OF NISPANIC | or No— 14. RACE — American Indian, Black, White, atc. | | | | | | | | |
| B | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR | | | 2 XNO Specify: | Specify: White | | | | | | | |
| | 15. DECEDENT'S EDI (Specify only highest grad | UCATION to complete of | 16a. DECEDENT'S | JSUAL OCCUPATION |)N | 16b. KIND OF BUS | | WILLOO | | | | | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+) | | ork done during mo retired.) | st of working | | | | | | | | |
| ₹ I | 12 17. FATHER'S NAME (First, Middle, Last) | | Homema | ker | | Own H | | | | | | | |
| | nfn | | | | | E (First, Middle, Maiden Jean Ann | | | | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street a | | ute Number, City or Town | | | | | | | |
| 임 | Linda Houdershe | ldt | | | | Cumberlar | | 21502 | | | | | |
| | 20a. METNOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Ren | novel from State | b. PLACE AND DATE O | F DISPOSITION (Na | me of | DATE 20c. LO | CATION — City or | | | | | | |
| | 4 1 Danetion 5 Other (Specify) | Da | avis Memoi | | | | mberland | i, MD | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE L | CENSEE | 1// | | elli Fune | | | | | | | | |
| ij | Jane - | 8 ca | olli | Cumbe | rland. M | 21502 | | | | | | | |
| | 23. PART Enter the diseases, or shock, or heart failure. | complications that csus | the desth. Do neech lina. | ot enter the mo | de of dying, such | ss cardiac or respi | ratory arrest, | Approximate interval Batween | | | | | |
| | iMMEDIATE CAUSE (Finel disease or condition | SEAC | , 5 | | | | | Onset and Death | | | | | |
| | rasulting in dasth) | a. SEAS | A CONSEQUENCE OF |): | | | | New Weeks | | | | | |
| Z | Sequentially list conditions, | b. DIFFUSE DUE TO (OR AS | SKIN | NE | chosis | | | Few Weeks Few Months Years | | | | | |
| CERTIFICATION | if sny, leading to immediate cause. Enter UNDERLYING | C. END 5 | A CONSEQUENCE OF | P.E. | 41 A | 105.00 | | 1/ | | | | | |
| 임 | CAUSE (Disease or injury that initieted events | DUE TO (OR AS | A CONSEQUENCE OF |): | | | | Xxxx | | | | | |
| E | resulting in death) LAST | · DIFFU | SE VA | SCULA | R Dis | EASE | | | | | | | |
| - 11 | PART ii. Other aignificant conditio | na contributing to death | but not resulting in | the undariving | cause given in P | art i 24a WAS AN | ALITOPSV 24 | Ib. WERE AUTOPSY FINDINGS | | | | | |
| MEDICAL | DIABETES | PERFORMED? | | | | | | | | | | | |
| | | | | | | 1 [] YES 2 | NO | OF DEATH? | | | | | |
| | DID TOBACCO USE | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO | | | | | | | | | | | |
| SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 28. PI OTHER: | ACE OF DEATN (Chec | k only one) | | | | | | | |
| HYS | 1 YES 2 AND | 1 9-Impetiant 2 ER/Ou 28a. DATE OF INJURY | tpstient 3 DOA | 4 - Nursing Hom | e 5 Residence 6 | | | | | | | | |
| ۱ ۵ | 1 Natural 5 Pending | (Month, Day, Year) | 28b. TIME INJU | JRY WC | RK? | 28d. DEŞCRIBE HOW II | NJURY OCCURED | | | | | | |
| D BY | 2 Accident Investigation 3 Suicide 8 Could not be | 28a. PLACE OF INJUR building, etc. (Sp | IY — At home, ferm, st | | | 281. LOCATION (Street a | and Number or Rura | l Route Number, | | | | | |
| ETED | 4 Nomicide determined | building, etc. (Sp | өспу) | | | City or Town, State) | | | | | | | |
| | | SICIAN: To the best of my kno | wledge, death occurre | d at the time, data | and place, and dua to | the cause(a) and men | ner as stated. | | | | | | |
| COMPL | one) 2 MEDICAL EXAMIN | IER: On the baels of examinati | on and/or investigation | n, in my opinion, d | esth occured at the ti | me, data and place, an | d due to the couse | e(a) and menner as stated. | | | | | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIE | ER A | (1) | 357061 | 29c. LICENSE NUMB | | | ED (Month, Day, Year) | | | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON W | who completes alles | 1 - | | D 1931 | 18 | • | | | | | | |
| | N. Ranjithan M.I | | own Road (| | nd MD 21 | 1502 | | | | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIG | NATURE | | | | <u></u> | | | | | | |
| | AUC 2 4 1994 | Haviden-Rand | all | | | | | | | | | | |
| | 11/00 % - 100 | | | | | | | | | | | | |

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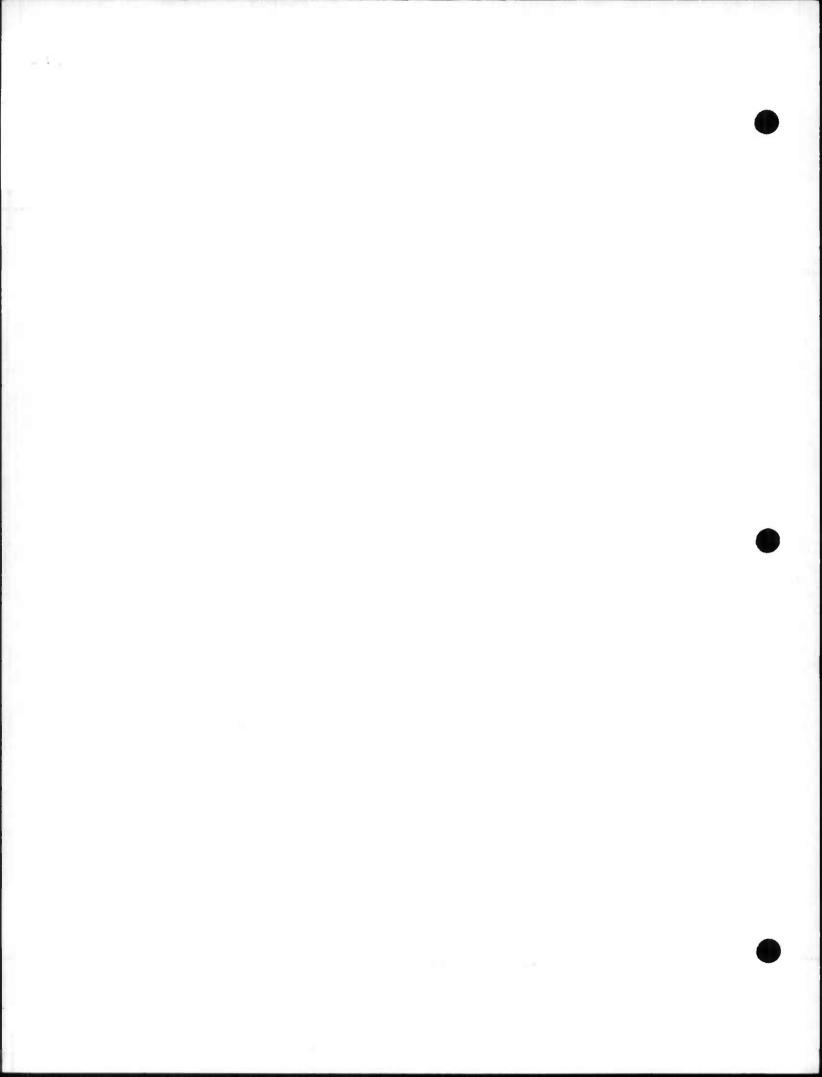
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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital or attending physician. |
|---|
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be find within 72 hours after death with the State Deor, of Health and Mental Monetoe prior to burial, cremation, or removal. |
| IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

1 - FOR STATE REGISTRAR STATE OF MARYLAND / OEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First | Middle, Last) | | | | - | | | | 2. DATE OF U | DEATH | | | 3. TIME OF DEATH |
|---------------|---|--|----------------------|---------------------|---|--|---|--------------------|------------------------|--------------------------------|------------------|--|---------------|------------------------|
| | | | | | | | | | | | | 1:24 P M | | |
| | 4. SOCIAL SECURITY NUME | BER | 5. SEX | 6. AGE (In yrs. la: | st birthday) | | IF UNDER 1 YEAR IF UNDER 24 HRS. | | | 7. DATE OF 8 (Month, De | HRTH | | | LACE (State or Foreign |
| | 163-14-5129 | 4-5129 ¹\\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | | | | MONTHS | DAYS | HOURS | MIN. | Jan. | 29, 1 | 1900 | Mar | yland |
| - | 9a. FACILITY NAME (If not in | stitution, give s | street and number) | | | 9b. CIT | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | ATH | |
| DIRECTOR | Garrett County Memorial Hospital | | | | | Oakland Garrett | | | | | | | | |
| L C | 10e. STATE 10b. COUNTY | | | | 10c. CI | 10c. CITY, TOWH OR LOCATION 10d. INS | | | | | 10d. INSIDE CITY | | | |
| 듬 | Maryland Garrett | | | | | iend | svil | 1e | | | | LIMITS? 1 YES 2XXNO | | |
| 4 | 10e. STREET AND NUMBER | | | | | | 10 | f. ZIP COD | E | | | 10g. CITIZEN OF WHAT COUNTRY? | | |
| ER | Route 1. Bo | | | | 215 | 31 | | | USA | | | | | |
| FUNERAL | 11. MARITAL STATUS | | | NT EVER IN U.S. AF | | 13. | WAS DEC | ENDENT (| OF HISPAN | IC ORIGIN? (S | pecify Yea | | 14. RACE | - American Indian, |
| BY F | 1 Never Married 2 3 | | IF YES, GIVE | MAR OR DATES | NO | | | | sn, Mexical Specify | n, Puerlo Rican | i, etc.) | | Specify | White, etc. |
| | 2 100 10 | | <u> </u> | | | | | 4% | | | | | | white |
| TED | | EDENT'S EDU y highest grade | | (0 | ECEDENT'S | work done | during me | ON ost of worki | ng | 166. KIND OF BUSINESS/INDUSTRY | | | DUSTRY | |
| COMPLET | Elementary/Secondary (0 | l-12) | College (1-4 or 5 | *) | | NOT use retired.) | | | | | | | | |
| N N | 7 th | liddle I setl | | I Car | pent | er | | 40.1107 | LIEBIO MA | Carpentry | | | | |
| | Horace Sisler | | | | | 18. MOTHER'S NAME (First, Middle Annie Beeghl. | | | | | | | | |
| BE | 19a. INFORMANT'S NAME (1 | | | 19 | h MAII IN | ANNES | S /Street | | | loute Number, C | | Ctata 7is | o Codel | |
| 임 | | | | | | | | | | | | | | |
| | 20a. METHOD OF DISPOSITION 20b PLACE | | | | | | | | Lini | | | D 21090 OCATION — City or Town, State | | |
| | Ty: Burial 2 Cremetion 3 Removal from State cometery con | | | | emptory or other place) ing Rose Cemetery 8-20-94 Fri | | | | | ł | • | | | |
| | 21. SIGNATURE OF FUNERA | L SERVICE LI | CENSEE | | | | | | | 111 | IIGS (| / 1.1.1. C | , 110 | |
| | DA 1/2 | 1) | X leux | 2111) | | | | | | l. Homes | | | | |
| | 155 Main St., Grantsville, MD 21536 | | | | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or reapiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between | | | | | | | | | | | | | |
| | IMMEDIATE CAUSE (Final Consett and De | | | | | | | | | | Onset and Death | | | |
| | resulting in deeth) | → | a | T.J | | | | | | | | | | 2 days |
| I _ I | resulting in deeth) a. Due to (or as a consequence of): Purmuna 2 days | | | | | | | | | | 2-0- | | | |
| <u>o</u> | Sequentially list conditions, DIE TO (OR AS A CONSCOURAGE OF) | | | | | | | | | | Longe | | | |
| AT | If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | | | |
| 표 | CAUSE (Disease or Injury that Initiated eventa DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | | | | | |
| | PART II. Other algoriticant conditions contributing to deeth but not resulting in the underlying cause given in Part 1 24e Was AN AUTODSV | | | | | | | | | | | | | |
| EDICAL | PART II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY FINDINGS AMPLIABLE PRIOR TO COMPLETION OF CAUSE | | | | | | | | | | | | | |
| | 1 U YES 2 NO COMPLETION OF CAUSE | | | | | | | | | | | | | |
| Σ | DID TOPACO | 1 UYES 1 NO | | | | | | | | | | | | |
| AN | 25. WAS CASE REFERRED T | | CONTRIBUT | E IO CAC | 13E O | r DEA | | | | ock only one) | | | | |
| PHYSICIAN: | EXAMINER? | | HOSPITAL: | ☐ ER/Outpatient : | n DOA | OTHE | R: | | | | | | | |
| ≚ | 27. MANNER OF DEATH | | 28a. DATE OI | | 28b. TII | _ | | JURY AT | asidenca | 8 Other (Sp 28d, DESCRIE | | JURY OC | CURED | |
| \ \ | 1 | Pending | (Month, I | Day, Year) | IN | JURY | W | ORK? YES 2 | □NO | | | | | |
| @ | a D a seed | Investigation | 28a. PLACE | OF INJURY — At he | ome, ferm, | streef, fed | | - | | 28f. LOCATIO | N (Street a | nd Number | r or Rural Ro | oute Number. |
| TED | | Could not be determined | building | , atc. (Specify) | | | | | | | wn, Stete) | | | |
| COMPLET | 29e. CERTIFIER 1 CERT | IFYING PHYS | ICIAN: To the best o | f my knowledge d | anth occur | red at the | time dete | and also | and due | to the saussia | \ and man | | 4-4 | |
| ₩ | Tomosii siin, | | | | | | | | | , | | | | end manner as stated, |
| | 29b. SIGNATURE AND TITLE | | | | | | | - | | | P.400, 611 | | | |
| 띪 | Iss. Grand one And the | 1 | | | | | | | ENSE NUM | | | 29d, DAT | E STONED | (Month, Day, Year) |
| 인 | 30. NAME AND ADDRESS OF | F PERSON WI | 10 COMPLETED CAL | ISE OF DEATH (ITE | M 271 /7un | e Print1 | | D- | 33464 | 4 | | * | 0/16 | 0(17 |
| | Robert Coug | | | | | | VIV. | 267 | 16 | | | | | |
| | 31. DATE FILEO (Month, Day, | | 32 REGISTRA | AR'S SIGNATURE | , EQ | TOIT, | VV 1/ | 207 | 10 | | - | | | |
| | AUG 2 | | 4 Plia da | volsor Rock | Land 1 | 1 | | | | | | | | |
| | | | // | | -0.40 | + | | | | | | | | DHMH-18 Rev 1/8 |
| | | | | | | | | | | | | | | DIMEN-19 MAY 1/85 |





ed by the hospital or attending physician. Nuld be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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| is ce | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached within 72 hours after death with the State harm of Health and Mental Homens nor in hiral framation or removal |

| | 1 - FOR STATE OF MARYLAI REGISTRAR | ND / DEPARTM | | | MENTAL HYGIENE REG. NO. | E | |
|-------------|--|--|--------------------|--------------------|--|--------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | PAUL E. STEININGER | | | | 8- 16 | 1994 YEAR | 9:45 A. m |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In | | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTI Count | IPLACE (State or Foreign |
| | 217-10-2003 | YRS. | THE DAYS | HOURS MIN. | 9-15-1912 | USA | A |
| | 9a. FACILITY NAME (If not institution, give street and number) | CITY, TOWN O | R LOCATION OF DE | ATH | 9c. COUNTY OF D | PEATH | |
| 5 | 8957 Star Road | Delm | nar | | Wicom: | ico | |
| ទួ | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY | 10c CITY TO | OWN OR LOCAT | ON | | | 10d. INSIDE CITY |
| DIRECTOR | Md. Wicomico | | | | LIMITS? | | |
| | | | | | | 10g. CITIZEN OF | |
| | 8957 Star Road | | | | | USA | |
| FUNERAL | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U | | | | IC ORIGIN? (Specify Yes | or No.— 14. RAC | E — American Indian, |
| BY F | 1 Never Married 2 Married FORCES? 1 YES 3 Widowed 4 Divorced FORCES? 1 YES, GIVE WAR OR DATE | | If yes, spe | | n, Puerlo Rican, etc.) | | k, white, etc. "y: White |
| | | | | | | | Wnite |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | (Give kind of work life. Do NOT use ret | done during mos | N It of working | 166. KIND OF BUS | INESS/INDUSTRY | |
| ا ٿ | Elementary/Secondary (0-12) College (1-4 or 5+) | Truck Dr | | | Comme | ercial | |
| <u> </u> | 17. FATHER'S NAME (First, Middle, Last) | II dek bi. | IVEL | 14 MOTHER'S NA | ME (First, Middle, Maiden S | | |
| | Charles V. Steininger | | - 1 | | Ellis Ste | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADI | DRESS (Street a | | loute Number, City or Town | 0 | |
| 임 | Jessie V. Steininger | | | | , Md. 2187 | | i |
| - | | LACE AND DATE OF D | | na of | DATE 20c. LOC | ATION — City or To | own, Stata |
| | | d Point | _{Cemete} | у | 8-19 Shad | Point, | Md. |
| - 1 | 21. SIGNATURE OF FUNERAL SERVICE LICENSEI | | | D ADDRESS OF FAC | Home, Inc | | |
| | Milley W. Hot | | | | St. Delmar, | | 940 |
| | 23. PART I. Enter the diseases, or complications that caused to abook, or haert failure. List only one cause on each | he death. Do not | | | | | Approximate |
| | IMMEDIATE CAUSE (Final | n line. | | | | | Interval Between Onsat and Death |
| | disease or condition - e. Metan | tatic | Ca | recivi | oma | | Zyrs. |
| | DUE TO (OR AS A C | | | | | | 1 |
| 8 | Sequentielly list conditions, DUE TO (OR AS A C | Now | - | UNG | | | |
| RTIFICATION | If any, lasding to immediate cause. Enter UNDERLYING | ONSEQUENCE OF): | | | | | i I |
| 윤ᆘ | CAUSE (Disease or injury that initiated events DUE TO (OR AS A C | ONSEQUENCE OF): | | | | | |
| | resulting in death) LAST | | | | | | |
| S | DADY II Other clerifficant conditions contained and on the | | | | | | |
| 8 | PART II. Other significant conditions contributing to death but | not resulting in the | | cause given in i | Part i. 24a. WAS AN A PERFORI | | . WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| MEDIC | The trees of | relita | | | t YES 2 | □ NO | OF DEATH? |
| | DID TOPACCO LICE CONTRIBUTE TO | CALICE OF I | DEATH A | /FC \ | | | 1 Tes 2 No |
| HYSICIAN: | DID TOBACCO USE CONTRIBUTE TO (25, WAS CASE REFERRED TO MEDICAL | CAUSE OF I | | CES NC | | | |
| SIC | EXAMINER? 1 YES 2 NO 1 Inpatient 2 ER/Outpati | | THER: | .5 ★ Residence | | | |
| H | 27. MANNER OF DEATH 28s. DATE OF INJURY | 28b. TIME OF | 28c, INJU | IRY AT | 28d. DESCRIBE HOW IN | JURY OCCURED | |
| ВУР | 1 Netural 5 Pending (Month, Day, Year) 2 Accident Investigation | INJURY | | ES 2 NO | | | |
| - 1 | 3 Suicide 8 Could not be 25e. PLACE OF INJURY — building, etc. (Specify | At home, ferm, stree | t, factory, office | | 28f. LOCATION (Street as City or Town, State) | nd Number or Rural | Route Number, |
| LED | 4 Homicide datarmined | | | | ony or lown, state) | | |
| 2 | 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the beet of my knowled | ge, death occurred at | the time, data | and place, and due | to the cause(a) and meni | ner as stated. | |
| COMPLET | one) 2 MEDICAL EXAMINER: On the basis of examination a | | | | | | a) and manner as stated. |
| w II | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | 29c. LICENSE NUM | BER | 29d. DATE SIGNED | (Month, Day, Year) |
| 0 | Online & Sulpelin | m.D | | 7)0 | 3599 | D 8. | 17-94 |
| F | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH | (ITEM 27) (Type), Prin | it) | | | | / |
| | JOHN T. BULKELEY, M.D., 108 PI | | ROAD, | SALISBUR | RY, MARYLAN | D, 2180 | 1 |
| | 31. DATE FILED (Month, Day, Your) AUG 1 8 1994 July Durcher's SIGNAT | URB II | | | | | |
| | TIOU I DISSI Jame Williams | - work | | | | | |

6A

BALTIMORE, MARYLAND 21215-0020

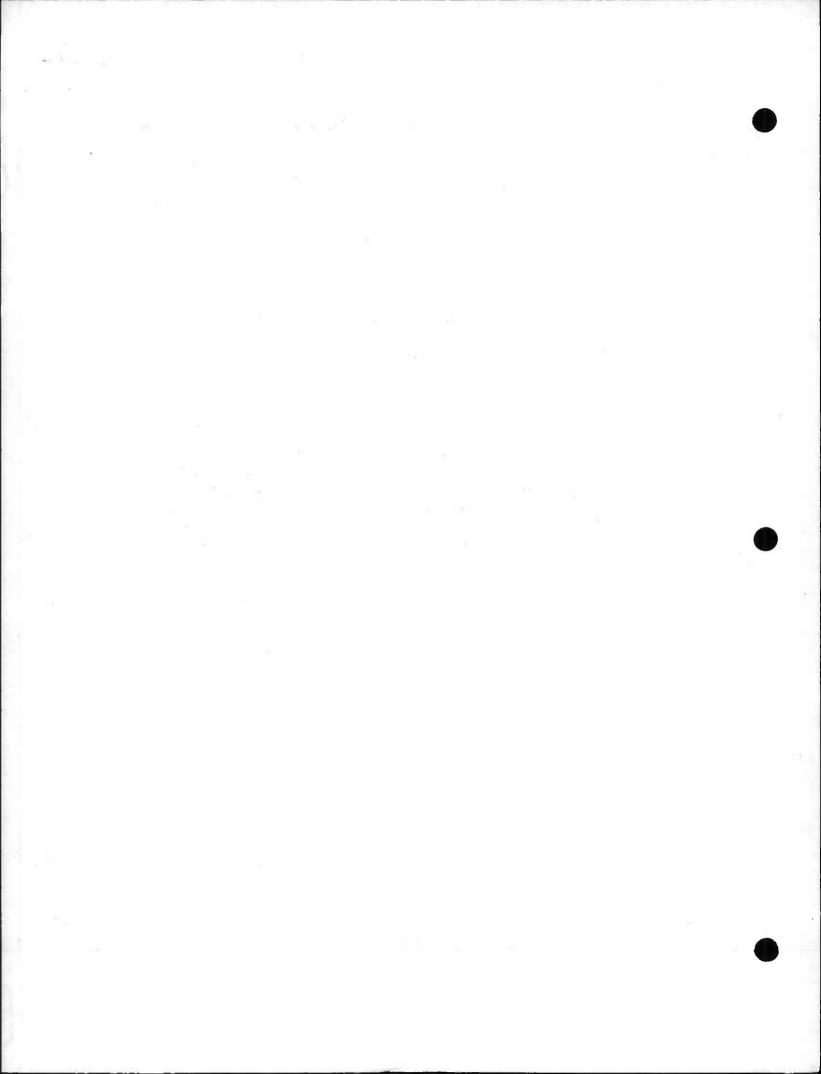
1 - FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| • | . 3 should | |
|---|---|---|
| | is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be called for use as the burial-transit permit. Pages 1, 2, 3 should be called the control of the state and Mental Hydrene prior to burial cremation, or removal | |
| | permit. P | |
| sician. | ial-transit | |
| ding phy | s the bur | |
| al or atter | for use a | |
| the hospit | detached | once. |
| ained by | should be | iffed at |
| nay be ret | page 5 s | t be no |
| Раде 6 п | al director, | ner mus |
| ter death. | the funer | ai exami |
| YSICIAN: The law requires that the death certificate be executed with nours after death. Page 6 may be retained by the hospital or attending physician. | s certificate has been signed by the attending physician and completely filled in by the in the State Deor, of Health and Mental Hydiene prior to burial, cremation, or removal | is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once |
| with. | cremation | went, th |
| e execute | an and co | umatic |
| ertificate t | ng physicl | other tra |
| e death co | Vental Hv | ury, or |
| es that the | alth and I | any In |
| aw require | s been sig | 3 show |
| IAN: The | tificate ha | or Item 2 |
| G PHYSIC | er this cer | arked, o |
| ATTENDIN | CTOR: After | 28 is rr |
| D THE HOSPITAL OR ATTENDING PHYS | O THE FUNERAL DIRECTOR: After this in filed within 72 hours after death with | MPORTANT: If Item 28 |
| THE HOSF | THE FUNE | PORTANT |
| 2 | 2 2 | ₹ |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| - 1 | 1. DECEDENT'S NAME (First, Middl | | | | | | 2 | DATE OF DEATH | 3/15/1 | 994 3 | . TIME OF DEATN |
|---------------|---|-------------------------------------|----------------------------|--|-------------------------|-------------------------|------------|---|---|---|-----------------------|
| T) | | ALINE J. | SOJKA | | 50 | JKA | | AUGUST | 15.19 | 194 | 0/15 " |
| | 4. SOCIAL SECURITY NUMBER | | . AGE (In yrs. last | M | F UNDER 1 YEAR | | 4 HRS. 7. | DATE OF BIRTH (Month, Day, Year) | Λ | 8. BIRTHPL Country) | ACE (State or Foreign |
| | 217-03-6015 | 1 □ M 2 💢 F | 79 | YRS. | | | F | eb. 10,1 | 915 | Whale | ysville,MD |
| DIRECTOR | \$6. FACILITY NAME (If not institution PENINSULA RE RESIDENCE OF DECEDE | L CENTE | | | SBURY | N OF DEAT | N | | OF DEA | | |
| E C | 10a. STATE 10b. COUNTY | | | | TOWN OR LO | CATION | | | | 1 1 | 0d. INSIDE CITY |
| | Maryland W | | Whal | eysvi | | | | | 1 | LIMITS? X YES 2 NO | |
| FUNERAL | 11501 Sheppar | d's Crossing | Road | | | 21872 |) | | | 109. CITIZEN OF WHAT COUNTRY? | |
| В | 11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced | | | 2 K NO If yes, specify Cuban, Maxican, Puarto Rican, etc.) | | | es or No— | No- 14. RACE — American Indian, Black, White, atc. Specify: White | | | |
| 뎶 | 15. DECEDENT (Specify only highe | 'S EOUCATION st grade completed) | 16a. DEC | CEOENT'S US | SUAL OCCUPA | TION most of working | | 16b. KIND OF B | USINESS/IND | USTRY | |
| COMPLETED | Elementary/Secondary (0-12) 6th | College (1-4 or 5+) | life. | (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | | | N | one | | |
| Ö | 17. FATHER'S NAME (First, Middle, I | ast) | | | | 18. MOTHE | R'S NAME | (First, Middle, Maide | | | |
| BE | Irvin Jarman | | | | | Ger | trud | e Dennis | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Pri | • | 19b | MAILING A | | | | te Number, City or To | | | |
| | Herbert Carey | | 7 | t. 1 | | | Dags | boro,Del | | | |
| | 20a METNOD OF DISPOSITION 1 LX Burlel 2 Crampiles 3 | | 20b. PLACE A | NO DATE OF | DISPOSITION r place) | | 0 (= = | | OCATION — | | |
| - 1 | 4 Donation 5 Other (Speci 21. SIGNATURE OF FUNERAL BER | | Date | Cemet | | AND ADDRESS | 8/1/ | /94 Wha | leysv: | ille, | Maryland |
| | · Also | To Hills | | | MEI | SON FU | NERA | L SERVIC LAWARE 1 | | TD. | |
| T | 23. PART I. Enter the disease | , or complications that of | eused the dec | eth. Do not | enter the | node of dyln | g, auch s | s cardiec or res | 9945 piratory arr | rest, | Approximate |
| | ehock, or heart failure. Liet only one ceuse on esch line. IMMEDIATE CAUSE (Final disease or condition resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST | AS A CONSECUTION AS A CONSECUTION | UENCE OF): | | | | | | 1-2-2-2-2-2-2-2-2-2-2-2-2-2-2-2-2-2-2-2 | | |
| MEDICAL | PART II. Other aignificant co | relie | 3 | | | ven in Pa | | IN AUTOPSY DRMED? | A C | PERE AUTOPSY FINDINGS WAILABLE PRIOR TO OMPLETION DF CAUSE F DEATH? YES 2 NO | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MED | Suparrules | auer | 120 | dij as | PLACE OF DE | ATM (Check | nett neet | | | |
| 밍 | EXAMINER? 1 YES 2 NO | HOSPITAL: | R/Outpatlent 3 | | THER: | | | Other (Specify) | | | |
| ¥ | 27. MANNER OF DEATH | 28e. OATE OF IN | JURY | 28b. TIME (| OF 28c. | NJURY AT | | d. OESCRIBE HOW | INJURY OCC | CURED | |
| BY | 1 Natural 5 Pendir 2 Accident Investi | | rour, | INJUR | | WORK? YES 2 | NO | | | | |
| | 3 Suicide 8 Could 4 Nomicide determ | | NJURY — At hore. (Specify) | ne, ferm, atre | et, factory, o | fice | 26 | Et. LOCATION (Stree City or Town, Stat | | or Rural Rou | te Number, |
| COMPLETED | | PHYSICIAN: To the best of m | | | | | | | | | nd manner as stated. |
| TO BE C | 296. SIGNATURE AND TITLE OF CERTIFIER BURGLACIO A | | | | | 29c. LICEN | 684 | 0 | 29d. DATE | 8/15/ | Porth, Day, Year) |
| | 30. NAME AND ADDRESS OF PERS | FLOADO M | OF DEATH (ITEM | 27) (Type, Pr | ine) FR | I'VERSI | De D | RIK & | VE 1131 | 34104 | Md. 2121 |
| | 31. DATE FILED (Month, Day, Year) AUG 1 9 1 | 32. REGISTRAR'S | SIGNATURE | | | | | • | | · · | - 150/ |
| | AUUISI | 134 Juna 010 | - Anna Lather | arty. | | | | | | | |



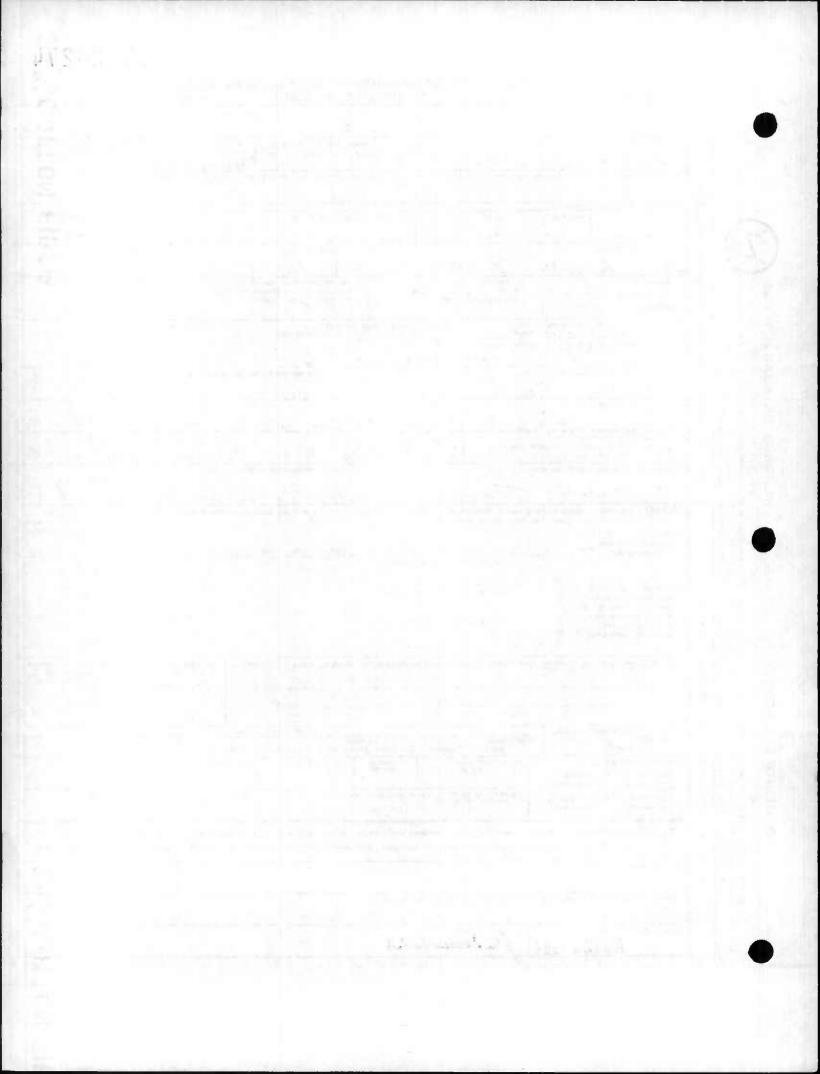
FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIFNE

| | | | IFICATE OF DEATH | REG. NO. | |
|---|---------------|---|---|--|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) JOHN THOMAS SNODGRASS | · · · · · · · · · · · · · · · · · · · | AUG. 22 1994 | 3. TIME OF DEATH 1:45 P M |
| 15 8 | | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birtho | MONTHS DAYS HOURS MIN | 7. DATE OF BIRTH 8. BIRTH (MONTH). 1990 Year 0 8 | THPLACE (State or Foreign |
| 10 | TOR | 99. FACILITY NAME (If not institution, give street and number) 3439 ADY ROAD RESIDENCE OF DECEDENT | 9b. CITY, TOWN OR LOCATION OF DI STREET | Sc. COUNTY OF HARFO | |
| (Z) | DIRECTOR | | STREET | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| ansit | FUNERAL | 100. STREET AND NUMBER 3439 ADY ROAD | 101. ZIP CODE 211 | 54 USA | WHAT COUNTRY? |
| MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-gansit notified at once. | BY | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 MED IF YES, GIVE WAR OR OATES | 13. WAS DECENDENT OF HISPAI If yea, specify Cuben, Mexica 1 TYES 2 NO Specifi | in, Puerto Rican, atc.) Bia | CE — American Indian, ck, White, etc. |
| 21215 al or atten for use as | COMPLETED | (Specify only highest grade completed) (Give kink Elementary/Secondary (0-12) College (1-4 or 5 +) | RT'S USUAL OCCUPATION If of work done during most of working T use retired.) | 16b. KIND OF BUSINESS/INDUSTRY | |
| YLAND 2 by the hospital be detached to | OMP | 12 FAR | | AGRICULTURE ME (First, Middle, Meiden Surneme) | |
| AYL/ | BE C | Edmund Shodgrass | JENNIE | TREAKLE | |
| MAR e retained e 5 should notified | 5 | 196. INFORMANT'S NAME (Type/Print) OLETA S. SINODGRASS 195. MAII 34. | ADY ROAD, ST | REET, MD., 21154 | |
| IORE, e 6 may b ector, pag | | 20a. METNOD OF DISPOSITION 1/\$\text{Specify}\text{ Update} 2 \text{Cremettery My reputity} 20b. PLACE AND OI cemettery My reputity} | ATE OF DISPOSITION (Name of Arr of TERY 8/ | 25/94 STREET, | Town, State |
| BALTIMORE, MAR' after death. Page 6 may be retained by the funeral director, page 5 should noval. cal examiner must be notified | Ì | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FA | .Inc., DELTA,PA | .,17314 |
| B/ hours after of od in by the or removal. | | 23. PART I. Enter the diseases, or complications that caused the death. I shock, or heart fellure. List only one cause pn each line. | o not anter the mode of dying, suc | h as cardiac or respiratory arrest, | Approximate interval Between |
| | | immediate cause (Final disease or condition resulting in death) | Jear fail | une | Onset and Death |
| OX 68760 e be executed with sician and completely filled not to bunial, cremation, traumatic event, the | Z | DUE TO (OR/AS A CONSEQUENCE POLICE) | EŎF): | | |
| BOX (cate be exemply sician and prior to the prior to the prior to the prior to the trauma | CATIO | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | E OF3: | | |
| OS, P.O. BOX 687(The death certificate be executed the attending physician and com Mental Hygiene prior to bunal, ijury, or other traumatic et | CERTIFICATION | CAUSE (Disease or injury that initiated events resulting in death) LAST | E OF): | | |
| ORDS, F that the death ed by the atter the and Mental any injury, o | L CE | PART II. Other significant conditions contributing to death but not resulti | ng in the underlying causa givan in | | b. WERE AUTOPSY FINDINGS |
| | DICAL | | | PERFORMED? | AVAILABLE PRIOR TO CDMPLETION OF CAUSE OF DEATH? |
| AL RECC s law requires has been sign Dept. of Healt | N: ME | | | _ | 1 TES 2 NO |
| 上年 9 8 6 | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpatient 2 ER/Outpetient 3 DO | 26. PLACE OF OEATN (Ch OTHER: A 4 Nursing Home 5 Totaldence | | |
| OF VI- | РНҮ | | TIME OF 26c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED | |
| VISION OF ATTENDING PHYS ECTOR: After this s after death with | D BY | 2 Accident Investigation 3 Suicide 26e. PLACE OF INJURY — At home, fa | M 1 YES 2 NO | 261. LOCATION (Street and Number or Rural | Route Number, |
| DIVISION OR ATTENDING DIRECTOR: After hours after death item 28 is man | ш | 4 Homicide determined | | City or Town, State) | |
| | COMPLET | 299. CERTIFIEN (Check only one) 2 MEDICAL EXAMINER: On the best of examination and/or investignment of the best of examination and/or investignment. | | | (e) end manner as stated. |
| 물 물을 품 | BEC | 296. SIGNATURE AND TIPLE OF CERTIFIER | 29c. LICENSE NUI | MBER 29d. DATE SIGNE | (Month, Day, Year) |
| ₽₽₽ ₹ | 2 | J. T. LEE M.D., 307 S. UNIC | | E CRACE MP | 184 |
| | | J.T.LEE M.D., 307 S. UNIC 31. DATE FILED (Month, Day, Your) AUG 26 1994 July Dawyson Warball | ON AVE, HAVRE D | E UKACE, MD., | |
| | M | HUULU IJJT A | | | |

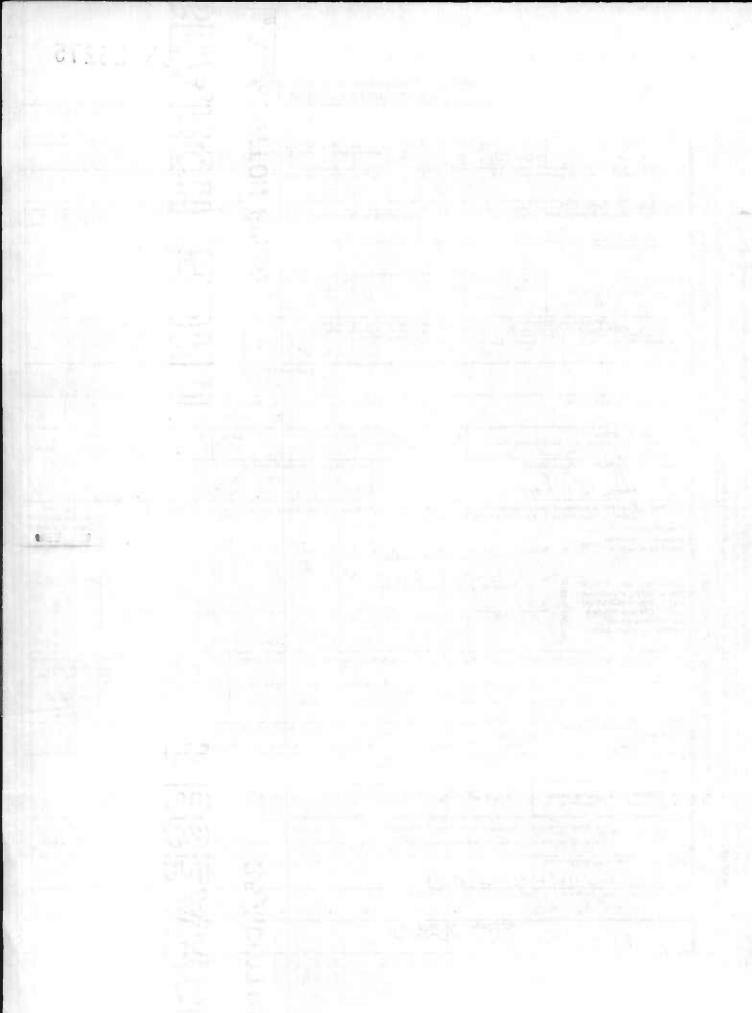
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| | 1 - STATE REGISTRAR | STATE OF MARY | | TMENT OF HE | | MENTAL HYGIE REG. N | | |
|-------------------------------|--|--|--|--|--------------------------------|--|--------------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 6 Le | STEVE | NSON | | 2. DATE OF DEATH MONTH AUGUST | 17 199 | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AG | E (In yrs. lest birthday) | | F UNDER 24 HRS.4 HOURS MIN. | Morth, Dey Year) | 8. | BIRTHPLACE (State or Foreign Country) |
| OR OR | Ga. FACILITY NAME (If not inatitution, give : SALISBURY NURSIN | | ENTER | 96. CITY, TOWN OR SALISBU | | M. T. | 9c. COUNTY | OF DEATH |
| DIRECTOR | RESIDENCE OF DECEDENT | ics Mico | 10c. CITY | ALISHE | 1 | | | 10d. INSIDE CITY LIMITS? 1 VES 2 NO |
| FUNERAL | 322 NAVLOA | SLAN | + | 101. 2 | 2/5/8 | 1 | 10g. CITIZEN | OF WHAT COUNTRY? |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widdiwed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YE IF YES, OIVE WAR OR | S 2 2 NO | If yes, spec | | NC ORIGIN? (Specify Yon, Puerto Rican, etc.) | Yea or No- 14. | RACE — American Indian, Black, Whita, atc. |
| PLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (912) | College (1-4 or 5+) | 16e. DECEDENT'S (Give kind of w | USUAL OCCUPATION rork done during most e retired.) | of working | 166. KIND OF B | USINESS/INDUST | II Park |
| ed at once. BE COMPLI | 17. FATHER'S NAME (First Middle, Last) | Magn | 78 MATILIAN | | 18. MOTHER'S NA | ME (First, Middle, Maide | 2 /21/- | is N |
| be netified TO BE | SHELLA UN | Xta | 322 | NAYLOR | . Str | Poute Number, City or To | Alishak | y ml. 21811 |
| must | 21. MITMOO OF DISPOSITION 1 | noval from State | ob PSACE AND DATE O bmetery, cremetory or att | ther place 5 | MAZM. | ¥26 S | STIBULY | for Town, state MI - 2/80/ |
| examiner | * Xuell. | -Frik | | tolk | 75 | 3/8 W | ISABE | |
| atic event, the medical | 23. PART I. Enter the diseases, or shock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. Can | ed the death. Do neach line. | 1 1000 | of dying, suc | - | piratory arrest | Approximate Interval Between Onset and Death |
| CATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | c | A CONSEQUENCE OF | | | | | Jan. |
| ERTIFICATION | that initiated events resulting in death) LAST | d | A CONSEQUENCE OF | 7: | | | | |
| amy min | PART II. Other algnificent condition | ne contributing to death | but not reaulting is | n the underlying | cause given in | | AN AUTOPSY ORMED? 2 D-NO | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| 23 N | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PLA | CE DF DEATH (Ch | eck only one) | | 1 TES 2 ND |
| or item | EXAMINER? 1 YES 2 HO | HOSPITAL: 1 Inpatient 2 ER/O | utpetlant 3 🗆 DOA | OTHER: 4 Nursing Home | 5 🗆 Residence | 6 ☐ Other (Specify) | | |
| marked, BY PH | 27. MANNER OF DEATH 1 Neturat 5 Pending 2 Accident Investigation | 28a. DATE OF INJUR (Month, Day, Year | Y 26b. TIME INJU | URY WORK | RY AT K? S 2 NO | 28d. DESCRIBE HOW | V INJURY OCCUR | ED |
| | 3 Suicide 6 Could not be 4 Homicide determined | 26s. PLACE OF INJU- building, atc. (S) | RY — At home, farm, s pecify) | treet, factory, office | | 28t. LOCATION (Stree City or Town, Stell | nt and Number or I le) | Rural Route Number, |
| TANT: If Item 28 is COMPLETED | ane) | ER: On the best of my kno | | | | | | use(a) and manner as stated. |
| IMPORTANT | 296. SIGNATURE AND TITLE OF CERTIFIE | 16 | 2 | | D29. | 349 | 29d. DATE SI | GNED (Month, Day, Year) |
| | 30. NAME AND ADDRESS OF PERSON WI William H. Robins 31. DATE FILED (Month, Day, Year) | MD., Rt. | 50 & E. M | | Salisbu | ry, MD 2 | 21801 | , |
| 2 | AUG 2 2 19 | 32. REGISTRAR'S SK | Hor Rardall | | | | | |



DHMH-18 Rev 1/89

| | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | |
|-------------|---|--|------------------------------|---|---|------------------------|--------------------------------------|---|--|--|
| | | usie Julia | Scesa | | | MONT | of DEATH | 1994 ^{YE} | 3. TIME OF DEATH 4:30 A | |
| | 4. SOCIAL SECURITY NUMBER 095-16-2239 | 5. SEX 6. AGE (| (In yrs. lest birthday) YRS. | IF UNDER 1 YEA | | 7. DATE (Mon Feb | of BIRTH | 4 N | SIRTHPLACE (State or Foreign Country) York | |
| OR | 9a. FACILITY NAME (If not institution, give William Hill He | · · · · · · · · · · · · · · · · · · · | | | n on LOCATION OF | | | 9c. COUNTY | of DEATH chester | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT Maryland To | albot | 10c. CITY, | 10c. CITY, TOWN OR LOCATION Easton | | | | | 10d. INSIDE CITY | |
| FUNERAL C | 100. STREET AND NUMBER 7821 Woodland C | | 1 | 101. ZIP CODE 21601 | | | 12 | XX YES 2 NO | | |
| BY FUNE | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D | 2XXNO | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Y If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 YES 2 ANO Specify: | | | | Vea or No — 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| COMPLETED | (Specify only highest grad | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) econdary (0-12) College (1-4 or 5+) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working time. Do NOT use retired.) HOMEMAKET | | | | | b. KIND OF BUSI | I INESS/INDUST | RY | |
| BE CO | | John Speranza | | | | | Middle, Maiden S Cialell | la | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) Ann Florence 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7821 Woodland Circle Easton, Md. 21601 | | | | | | | | | |
| | 20a. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Rer 4 Donation 5 Other (Specify) | novel from State 20b | PLACE AND DATE OF | er place! aven (| (Name of Cemetery | 8/ | | | or Town, State Sant, New Yo | |
| RTIFICATION | 21. SIGNATURE OF FUNERAL SERVICE L | DENSEE | | Thom | and address of F las Funera Locust St | al Ho | | e, Md. | 21613 | |
| | 23. PART I Enter the diseases, or shock, or heart fellure IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. Sub ci Due to (on as a Due to (on a) Due to (| QUCHNUI CONSEQUENCE OF | d h | Emorrh | | | atory arross, | Approximate interval Bette Onact and I STA WEE | |
| MEDICAL CE | PART II. Other algnificant condition | ne contributing to deeth b | out not reaulting in | the underl | ying cause given i | n Part I. | 24a. WAS AN A PERFORI 1 TYES 2 | MED? | 24b. WERE AUTOPSY FIND MAILABLE PRIOR TO COMPLETION OF CAL OF DEATH? 1 YES 2 NO | |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpetient 2 ER/Outp | | OTHER: | PLACE OF DEATH (C | | | | | |
| Y PHY | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME INJU | OF 28c. | INJURY AT WORK? YES 2 NO | 7 | SCRIBE HOW IN | JURY OCCUR | ED | |
| TED B | 3 Suicide a Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Spec | — At home, farm, at | reet, factory, c | ffice | | CATION (Street ar or Town, State) | nd Number or R | tural Route Number, | |
| COMPLE | | BICIAN: To the best of my know ER: On the basis of examination | | | | | | | use(s) end menner as stat | |
| TO BE C | 29b. SIGNATURE AND TITLE OF CERTIFIE | Harris n | ATH (ITEM 27) (Free) | Driet | 29c. LICENSE NO. | UMBER 707 | | 29d. DATE SIG | BNED (Month, Day, Year) | |
| | Rosemary M. Ha | arris, M.D. | 408 By | | . Cambr | idge | , Md. | 2161 | 3 | |
| | AUG 2 4 19 | 32. REGISTRARIS SIGN | ion-Rardall | | | | | | | |



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| should | | otified |
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| lirector, | | r must |
| funeral | o the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | , or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| the | Mal. | 10 |
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OR ATTENDING PHYSICIAN: The law

marked, or

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30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

AUG 2 6 1994

Pow 6

32. RESISTRAR'S SIGNATURE ROLLS

With

DIRECTOR: After the hours after death v

TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 HOUR IMPORTANT: If it

94 26276 asp FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATN AUGUST 22 1994 BARRY SCHWIEN 9:15 ALAN AM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTNPLACE (State or Foreign MONTHS DAYS NOURS 214-76-7494 1 X M 2 🗌 F 30 Jan. 2, 1964 Washington DC 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR RTE# 301 & CEDARVILLE ROAD PRINCE GEORGES BRANDYWINE RESIDENCE OF DECEDENT 10b. COUNT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Brandywine 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 16706 Cedar Forest Road 20613 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. It yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 X Never Married 2 Married 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced White 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only Ы College (1-4 or 5+) 12 COMPL Vending Machine Techniciah Vending Company 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) Mark Donald Schwien BE Marianna H. Robey 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Marianna H. Schwien 16706 Cedar Forest Road, Brandywine, MD 20613 20a. METNOD OF DISPOSITION

N☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — Cify or Town, State St. Peter s Cemetery 8-26 Waldorf, MD 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark G. Brohawn 22. NAME AND ADDRESS OF FACILITY Huntt Funeral Home Has M00053 P. O. Box 156, Waldorf, MD 20604-0156 23. PARTI. Enter the diseees, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ehock, or heart failure. List only one cause on each line Intervei Between IMMEDIATE CAUSE (Finel Onset and Death disease or condition shot wound of Head ontact Gun resulting in desth) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly list conditions, if any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF): e. Enter UNDERLYING CAUSE (Disesse Dr injury DUE TO (OR AS A CONSEQUENCE OF): that initiated evente resulting in deeth) LAST PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24s. WAS AN AUTOPSY PERFORMED? TYES 2 NO **DF DEATH?** YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\square\) NO \(\square\) UNCERTAIN \(\square\) PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) HOSPITAL OTHER: 1 X YES 2 NO Inpstlent 2 ER/Outpstlent 3 DOA 4 Nursing Nome 5 Residence 8 N Other (Specify) SCENE 26b. TIME OF INJURY 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DEŞCRIBE NOW INJURY OCCURED 1 Natural 09.15 M -22-94 Sho 1 YES 2 NO usiect В 2 Accident 3 Suicide
4 Nomicide 26a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be Roadnac determined 29a. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date and place, and due to the cause(e) and manner as stated. TI MEDICAL EXAMINER: On the beals of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER AUGUST 23, 1994 BE

O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

In the order to be the following

1

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Thours after death, Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit pegmit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

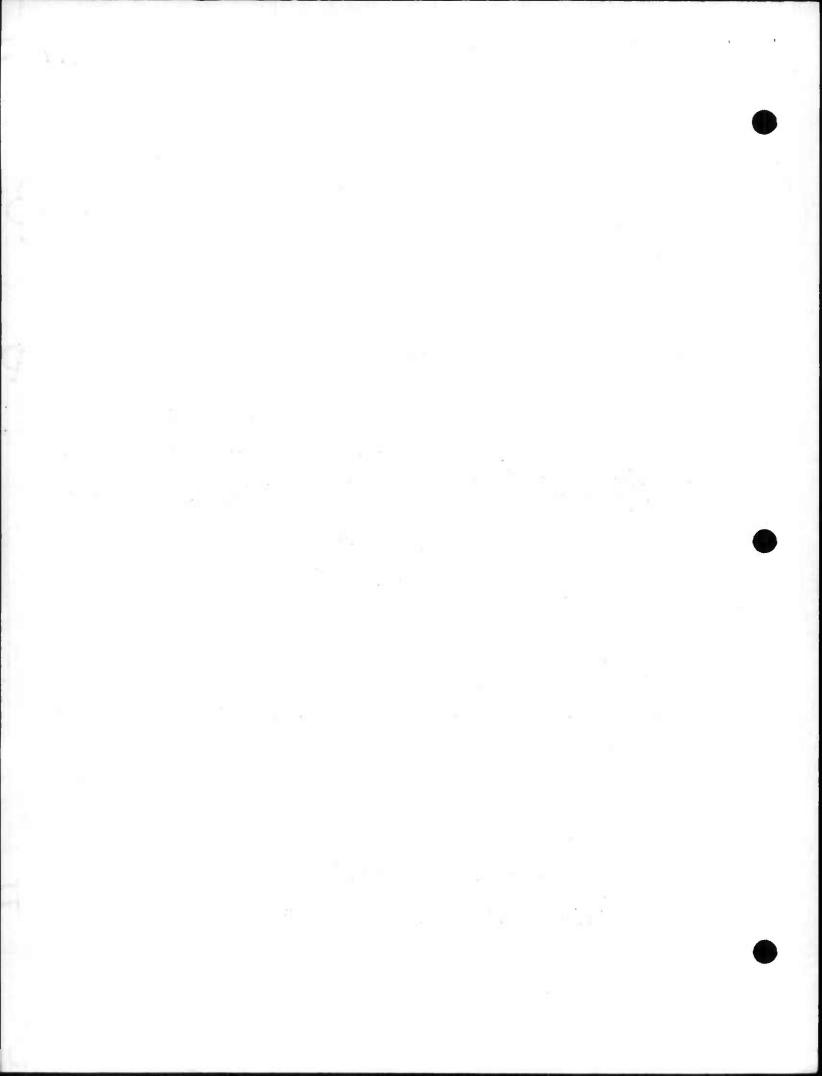
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

31. DATE FILED (Month, Day, 1947)
AUG 0 9 1994

Jalin Dander hardall

| | 1 - STATE REGISTRAR | STATE OF MARYL | | | ENT OF H | | ENTAL HYGIEN | | |
|----------------------------------|--|--|---|--|--|--|---|-----------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| ľ | Joseph | Paul | S | wales | | | August 8. | 1994 YE | 9:10 A M |
| | 34 VSC // 315 | and the second s | (In yrs. last | | UNDER 1 YEAR | | 7. DATE OF BIRTH | 6. 8 | BIRTHPLACE (State or Foreign Country) |
| ļ | 217-44-3853 1 9a. FACILITY NAME (# not institution, give street | M 2 F 4' | 7 | YRS. | | R LOCATION OF OEAT | | 1947 1 | Maryland |
| E I | St. Mary's Nursin | | | | Leonard | | in . | St. N | Mary's |
| 5 | RESIDENCE OF DECEDENT | | | | | | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY | Morreto | - 1 | | WN OR LOCAT | | | | 10d. INSIDE CITY LIMITS? |
| | Maryland St. | Mary's | | rexT | ngton | ZIP CODE | | | 1 VES 2 NO |
| FUNERAL | 8002 Spring Valley | Court | | | 101 | 20653 | | | U.S.A. |
| | 1 Never Married 2 Married | FORCES? 1 YES | 2 X NO | | If yes, spe | ENOENT OF HISPANIC ecity Cuban, Mexican, 2 NO Specify | ORIGIN? (Specify Yes Puerto Rican, etc.) | | RACE — American Indian, Black, White, etc. Specify: |
| BÁ | 3 Widowed 4 Divorced | | | | | | | | Втаск |
| | 15. DECEDENT'S EDUCATI (Specify only highest grade com | ON spleted) | (Give | EOENT'S USU b kind of work Do NOT use ret | AL OCCUPATIO | N st of working | 16b, KIND OF BU | SINESS/INDUST | RY |
| COMPLETED | 10th Grade | College (1-4 or 5+) | | aborer | wed.) | | Const | ructio | n |
| BE CO | 17. FATHER'S NAME (First, Middle, Last) James Walter | Milburn | | | | Mary Eli | E (First, Middle, Meiden Zabeth | Swale | S |
| 0 | 190. INFORMANT'S NAME (Type/Print) Catherine Swales | | | | | nd Number or Rural Ros , Lexingt | | | |
| | 20a METHOD OF DISPOSITION 1 Buriet 2 Cremetion 3 Removal | | | | SPOSITION (Na | | | CATION — City | or Town, State |
| | 4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENS | | larre | S MEIK | | O ADDRESS OF FACIL | | Onarut | owii, Marytand |
| | · Michael L | Ladine | .) | | Mattir | ngley-Gard | diner Fun | | |
| | 23. PART L Enter the diseases, or com | plicatione that caused | d the dee | th. Do not e | nter the mo | de of dying, such | as cerdiac or resp | iratory arrest, | Approximate |
| | IMMEDIATE CAUSE (Fine) | T) | A CIT IIII | | 4 | _ | | | interval Between Onset and Death |
| | diseese or condition resulting in death) e | Cal | va. | nom | alox | W | | ~ | moulhs |
| _ | | DUE TO (OR AS A | 1 | 4. | 14 | Ca Trum | 0 | | 12001 |
| HIFICATION | Sequentially liet conditions, if any, leading to immediate | OUE TO (OR AS A | A CONSEOU | | 0// | vine pr | / | | Dark) |
| 3 | cause. Enter UNDERLYING CAUSE (Disease or Injury | | | | / | | | | 10 |
| = | that initiated evente reaulting in deeth) LAST | DUE TO (OR AS A | CONSECU | JENCE OF): | - 1 | | | | |
| CER | d | | | | | | | | |
| AL | PART II. Other significent conditions of | | | | | | | | |
| | TARTO IN CUITO SIGNATURE CONDITIONS C | ontributing to death b | out not re | suiting in th | e underlying | ceuse given in Pa | | | 24b. WERE AUTOPSY FINDINGS |
| | TAIL III OURS SIGNIFICANT CONDITIONS C | ontributing to death b | out not re | suiting in th | e underlying | ceuse given in Pa | PERFO | RMEO? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDIC | | ontributing to death b | out not re | suiting in th | e underlying | ceuse given in Pa | | RMEO? | AVAILABLE PRIOR TO |
| MEDIC | DID TOBACCO USE CO | | | | EATH YI | :S NO | PERFOR | RMEO? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDIC | DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | NTRIBUTE TO | CAUSI | OF D | EATH YI | | PERFOR | RMEO? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDIC | DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | NTRIBUTE_TO | CAUSI | DOA S | EATH YI 26. PL HER: Nursing Hom | ES NO ACE OF OEATH (Check | PERFOR | AMEO? | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| PHYSICIAN: MEDIC | DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 27. MANNER OF DEATH 1 Netural 5 Pending | NTRIBUTE TO OSPITAL: Inpatient 2 ER/Outs | CAUSI | OF D | EATH YI | ES NO ACE OF OEATH (Check 5 Residence 6 187 AT 2 | PERFOR | AMEO? | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDIC | DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 11 27. MANNER OF DEATH | NTRIBUTE TO OSPITAL: Inpatient 2 ER/Outs 268. DATE OF INJURY | CAUSI | DOA QT | EATH YI 26. PL Worling Home WO 1 U Y | ES NO ACE OF OEATH (Check 5 G Residence 6 JRY AT 2 RK7 ES 2 NO | PERFOR | NJURY OCCURE | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDIC | DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | NTRIBUTE TO OSPITAL: Inparient 2 ER/Outp 26a. DATE OF INJURY (Month, Day, Year) 26a. PLACE OF INJURY building, etc. (Speci | CAUSI | DOA 450 DOA 450 INJURY | Z6. PL HER: Nursing Hom 28c. INJI WO 1 Y 1, fectory, office | ACE OF OEATH (Check 5 Residence 6 RRY AT RRY ES 2 NO | PERFORM 1 YES 2 Nonly one) Other (Specify) Bed. DESCRIBE HOW I City or Town, State) | NJURY OCCURE | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDIC | DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | NTRIBUTE TO OSPITAL: Inparient 2 ER/Outs 26a. DATE OF INJURY (Month, Day, Year) 26a. PLACE OF INJURY building, etc. (Spec | CAUSI — At homology, dear | DOA 400 23b. TIME OF INJURY | Z6. PL HER: Nursing Hom 28c. INJI WO 1 | ACE OF OEATH (Check 5 Residence 6 RRY AT RRY ES 2 NO 2 and place, and due to | PERFORM 1 YES 2 Nonly one) Other (Specify) 186. DESCRIBE HOW I City or Town, State) | NJURY OCCURE | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BE COMPLETED BY PHYSICIAN: MEDIC | DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | NTRIBUTE TO OSPITAL: Inpatient 2 ER/Outs 26a. DATE OF INJURY (Month, Day, Year) 26a. PLACE OF INJURY building, etc. (Special Control of the property o | CAUSI / At homology rledge, death in end/or in | DOA 25 28b. Time Of INJURY tia, ferm, street th occurred at the occurred at th | EATH YI 26. PL Nursing Hom 28c. INJI WO 1 Y t, fectory, office the time, data my opinion, de | ACE OF OEATH (Check 5 Residence 6 RRY AT RRY ES 2 NO 2 and place, and due to | PERFORM 1 YES 2 Nonly one) Other (Specify) 28d. DESCRIBE HOW I 28f. LOCATION (Street City or Town, State) the cause(e) end maine, date and place, and | NJURY OCCURE | AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Warel Route Number, Description of Cause of Death of Cause of Death of Cause of Death of Cause of Death of Cause of Death of Cause of Death of Cause of Death of Cause of Death of Cause of Death of Cause of Death of Cause of Death of Cause of Death of Cause of Death of Death of Cause of Death of Cause of Death of Death of Cause of Death |
| COMPLETED BY PHYSICIAN: MEDIC | DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | NTRIBUTE TO OSPITAL: Inparient 2 ER/Outs 26a. DATE OF INJURY (Month, Day, Year) 26a. PLACE OF INJURY building, etc. (Spec | CAUSI / At homology rledge, death in end/or in | DOA 25 28b. Time Of INJURY tia, ferm, street th occurred at the occurred at th | EATH YI 26. PL Nursing Hom 28c. INJI WO 1 Y t, fectory, office the time, data my opinion, de | ACE OF OEATH (Check 5 5 Residence 6 JRY AT RK7 ES 2 NO 2 and place, and due to the time of time of the time of time of the time of t | PERFORM 1 YES 2 Nonly one) Other (Specify) 28d. DESCRIBE HOW I 28f. LOCATION (Street City or Town, State) the cause(e) end maine, date and place, and | NJURY OCCURS | AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Warel Route Number, Description of Cause of Death of Cause of Death of Cause of Death of Cause of Death of Cause of Death of Cause of Death of Cause of Death of Cause of Death of Cause of Death of Cause of Death of Cause of Death of Cause of Death of Cause of Death of Death of Cause of Death of Cause of Death of Death of Cause of Death |

DHMH-16 Rev 1/89

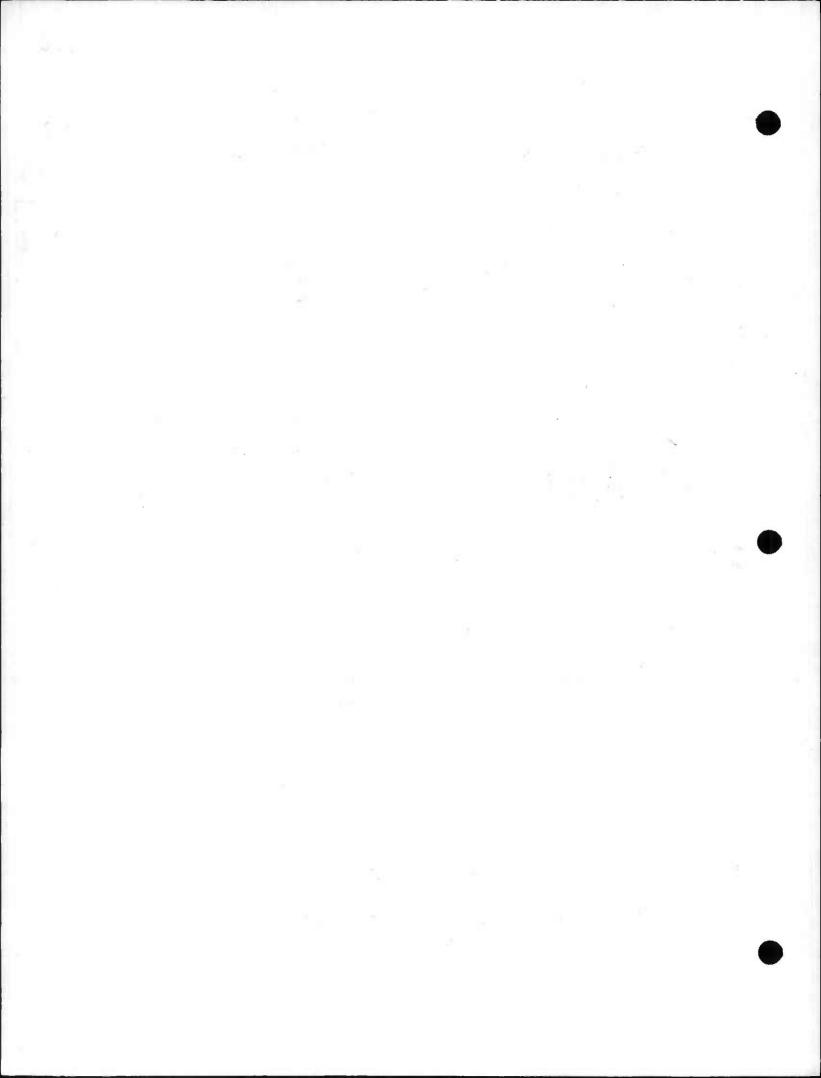


| BALTIMORE, MARYLAND 21215-0020 | 24 hours after death. Page 6 may be retained by the hospital or attending physicia | ly filled in by the funeral director, page 5 should be detached for use as the burial-tration, or removal. | the medical examiner must be notified at once. |
|---|--|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-tra | IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1 - REGISTRAR | | CERTIF | ICATE C | F DEATH | REG. NO |). | | |
|----------------------|--|---|------------------------------------|---|-------------------------------|---|--------------|-------------|--|
| | t. DECEDENT'S NAME (First, Middle, Last) | _5 ' | amuel Shupp | SHUPP | | 2. DATE OF DEATH MONTH | 4 | YEAR 94- | 3. TIME OF DEATH (049AM |
| | 4. SOCIAL SECURITY NUMBER 220-16-1490 | 1 X M 2 🗆 F | GE (in yrs. last pirthday) 70 YRS. | IF UNDER 1 YEAR | B HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Feb. 28, 19 | | Mar | yland |
| TOR | 96. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH WASHINGTON RESIDENCE OF DECEDENT 96. COUNTY OF DEATH WASHINGTON | | | | | | | | |
| DIRECTOR | 10a. STATE 10b. COUNT | ington | | ear Spr | | | | | 10d. INSIDE CITY LIMITS? t YES 2 NO |
| FUNERÅL | 106. STREET AND NUMBER 11520 Charles Mi | 11 Rd. | | | 101. ZIP CODE 21722 | 10g. CITIZEN USA | | | HAT COUNTRY? |
| BY | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR O | ES 2 NO | If yes | specify Cuben, Mexica | NDENT OF HISPANIC ORIGIN? (Specify Yes or No— city Cyben, Maxican, Puerto Rican, etc.) | | | - American Indien, White, etc. White |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (t-4 or 5+) | (Give kind of life. Do NOT u | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Installer Fence Installa | | | | | |
| BE CON | 17. FATNER'S NAME (First, Middle, Lest) Andrew | Smith | Shupp | | 18. MOTHER'S NA Bertl | ME (First, Middle, Melder na Mae | | Sta | ley |
| TO B | Bettie J.Hornbake | r-Shupp | | | | noune Number, City or Too d. Clear S | | | 21722 |
| | 20a_METNOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Rem 4 Donation 6 Other (Specify) | oval from State | 206. PLACE AND DATE | or disposition | Park Aug.26, | 1994 Hag | ersto | | vn, State MD.21740 |
| | 21. SIGNATURE OF EUNERAL SPRINCE LA | Jan- | b | OSBO | RNE FUNER | AL HOME Williamsp | ort M | ID 21 | 705 |
| | 23. PART I. Enter the diseases, or ahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | List only one ceuse of | sed the deeth. Do not eech line. | not enter the | mode of dying, suci | h as cardiac or resp | iratory arre | eat, | Approximete Interval Between Onset and Death |
| CERTIFICATION | Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted evente resulting in deeth) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part t. PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part t. PERFORMED? 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO | | | | | | | | |
| YSICI/ | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | Putpatient 3 🗆 DOA | OTHER: | PLACE OF DEATH (Chi | ALLOW A PARTY OF | | | |
| ву рн | 12 Natural 5 Pending 2 Accident Investigation | 28s. DATE OF INJUI (Month, Day, Mu | | JURY | HJURY AT WORK? YES 2 BO | 28d. DESCRIBE HOW | INJURY OCC | URED | |
| | 3 _ Suicide 6 _ Could not be determined | 38s. PLACE OF INJ | HY — at home, farm, | atradet, factory, o | ttice | 281. LOCATION (Street CIP. Ly State, HISTO | and Homble | or Runii Ro | outs Mumber |
| COMPLETED | | ICIAN: To the best of my ki | | | | | | | end manner as stated. |
| BE | 295. SIGNATIONE AND TYLE OF GENTINE | must | m | D | 29c. LICENSE NUN | 18ER | 29d. DATE | signed - 2 | (Month, Day, Year) 5-34 |
| 10 | ME Byrk | | | | sport | ma | 2 | 17 | 75 |
| | 31. DATE FILED (Month, Day Year) AUG 2 6 1994 | 32. REGISTRAR'S S | IGNATURE | | | | | | 1 3 |



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31. OATE FILED (Month, Day, Year)

AUG 25

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|------------------------------------|---------|--|---|----------------------------|--|---|------------------|---|
| | | 1 - FOR STATE OF MARYLAND REGISTRAR | / DEPARTM | ENT OF HE | ALTH AND N | MENTAL HYGIEN | E | |
| | | 1. DECEDENT'S NAME (First, Middle, Last) Charles Adrian 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs.) 212 - 75 - 4135 NO M 2 0 F | SKII | rve MDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 2. DATE OF DEATH MONTH DATE OF BIRTH (Morth, Day, Year) | 3 94 | 3. TIME OF DEATH 3. TIME OF DEATH 3. TIME OF DEATH 1333 3 INTHPLACE (State or Foreign ountry) |
| | TOR | 9a. FACILITY NAME (If not institution, give street and number) West Campus Dy. RESIDENCE OF DECEDENT | 96. | 1 | LOCATION OF DE | ATH | 9c. COUNTY | OF PEATH A |
| | T DIREC | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. STREET AND NUMBER 4524 Chandlers For de | 10c. CITY, TO | ARAS | ATO | | | 10d, INSIDE CITY (LIMITS? 1 YES 2 ONO |
| and the | FUNERA | 4524 Ch And RVS For de 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. 1 Never Married 2 Married FORCES? 1 YES 2 | | 13. WAS OECE | ZIP CODE 3 4 2 NDENT OF HISPANI Hy Cuban, Maxican | IC ORIGIN? (Specify Yes | or No.— 14. F | OF WHAT COUNTRY? RACE — American Indian, Black, White, atc. |
| | | 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 15. DECEDENT'S EDUCATION 188. | DECEDENT'S USUA (Give kind of work d | 1 TYES 2 | NO Specify. | | | south the |
| | OMPLE | Elementery/Secondary (0-12) College (1-4 or 5+) 7 17: FAIHER'S NAME (First, Middle, Lest) | ille. Do NOT use relin | ~T-01 | uner | Real 2 | State | Brokery. |
| otified at o | 盟 | W Varies A. SHIV | | | A Number or Rural R | O-Ard oute Number, City or Town | ler | ») |
| examiner must be notified at once. | | 20a. METHOD OF DISPOSITION 1 Genetics School Superior State 4 Donation 5 Other (School Superior State Superior State Superior Sup | E AND DATE OF DIS | | B-24- | OATE 20c. LO | CATION - CHY | or Town, State We, MP |
| al examine | | 21. SIGNATURE OF FUNERAL SERVICE LICENSES | 1 | BARRI | ADDRESS OF FAC | AND SON | S Fy | MERALHOM MO SILLCE |
| event, the medical | | 23. PARTA. Entar the diseases, or complications that caused the shock, or heart feliure. Liet only one cause on each limit immediate Cause (Final disease or condition resulting in death) a. OUE TO (OR AS Y CONS | na. IN L | | | , Che | | Approximate Interval Between Onset and Death |
| or other | | Sequentially list conditions, if any, lasding to immediate cause, Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST b. DUE TO (OR AS A CONS or Injury that initiated events are sufficiently in deeth) LAST | • | | | | | |
| 8 : | Σ∥ | PART II. Other significant conditions contributing to deeth but not | t resulting in the | e undarlying | cause given in F | Part I. 24s. WAS AN PERFOR 1 YES 2 | MED? | 24b. WERE AUTOPSY FINDINGS AVARABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| Ee S | | 25. WAS CASE REFERREO TO MEDICAL EXAMINER? YES 2 \(\text{NO} \) NO 1 \(\text{Impatient 2} \) ER/Outpatient | | HER: | CE OF DEATH (Che | . 7 | | 1- |
| arked, o | | 27. MANNER OF OEATH 27. MANNER OF OEATH 1 Netural 5 Pending Investigation 28a. DATE OF INJURY (Month, Dey, Year) 8 23 94 | 28b. TIME OF INJURY | 28c. INJUE WORI 1 YE | RY AT K? | 28d. DESCRIBE HOW II | NJURY OCCURE | |
| 28 Is | | 3 Suicide 8 Could not be determined 28s. PLACE OF INJURY — At building, stc. (Specify) | 043 | | | 281. LOCATION (Street a Arvolo | (, m | ral Route Number, |
| TANT: II | - 18 | (Check only one) 2 MEDICAL EXAMINER: On the beals of examination end/o | | my opinion, dea | th occured at the t | ime, data and placa, an | d due to the cau | |
| IMPOR | ۱۱۱ | 30. NAME AND ADDRESS OF PERSON WITH LIFE CAUSE OF GRATH IN | Deput | 4 | DO6 | 054 | P 8 | 13/9, 4 |

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1984 Julia duwlar Rarlell

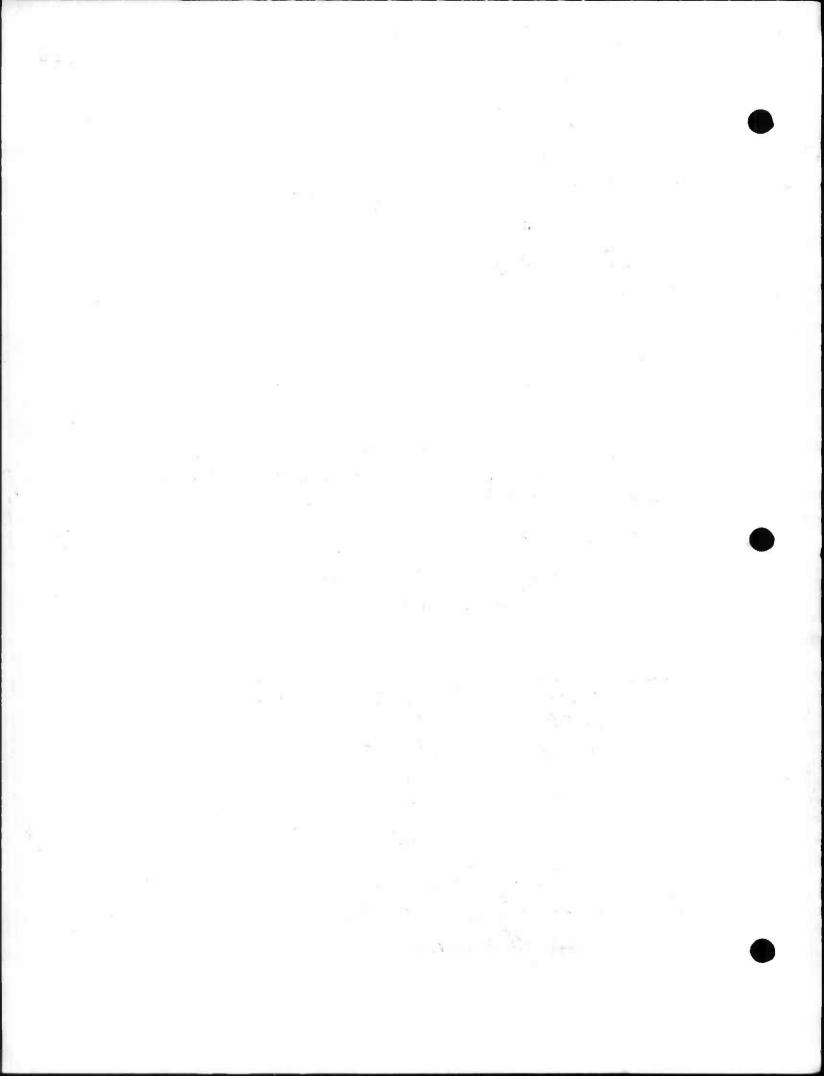
21035

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR C | ERTIFIC | ATE OF | DEATH | R | EG. NO. | | | | | | |
|---------------|--|--|-----------------------|-----------------------|------------------------------|-------------------------------------|-------------------|---|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) ALVERTA SIMMS | | | | 2. DATE OF E | DEATH | YEAR | 3. TIME OF DEATH | | | | |
| | | | | | OS | 16 | 94 | 1:25 1.4 | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. In $2\sqrt{F}$ 6. G | - | ONTHS DAYS | HOURS MIN. | 7. DATE OF B (Month, Day | r. Year) | Countr | HPLACE (State or Foreign ry) | | | | |
| P | 9e. FACILITY NAME (If not institution, give street and number) | | h CITY TOWN | OR LOCATION OF DE | 05-1 | | MARY | YLAND | | | | |
| TOR | 96. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DEATH 96. COUNTY OF DEATH 96. COUNTY OF DEATH 96. COUNTY OF DEATH | | | | | | | | | | | |
| DIRECTOR | 106. STATE 10b. COUNTY MARYLAND ANNE ARUNDEL | | APOLIS | TION | - | | | 10d. INSIDE CITY LIMITS? 1 Pres 2 NO | | | | |
| FUNERAL | 100. STREET AND NUMBER 1126 EASTPORT TERRACE | | 10f. ZIP CODE 21403 | | | | | WHAT COUNTRY? | | | | |
| В | 11. MARITAL STATUS 1 Never Merried 2XX Merried 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. A. FORCES? 1 YES 2X IF YES, GIVE WAR OR DATES | IF YES GIVE WAR OR DATES | | | | | Black | E — American Indian, k, White, etc. | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | | | |
| O | 17. FATHER'S NAME (First, Middle, Last) | DOLLEG | 110 | 18. MOTHER'S NA | ME (First, Middle | , Meiden Surn | ame) | | | | | |
| BE C | ENOCH BUTLER | | | ROSET | TA BRO | WN | | | | | | |
| TO B | 19e. INFORMANT'S NAME (Type/Print) | b. MAILING AI | ODRESS (Street a | and Number or Rural F | Route Number, C | ity or Town, St | ete, Zip Code) | | | | | |
| - | HAZEL OFFER 1 | 125 MA | DISON : | ST. APT. | A4 ANN | APOLIS | S, MD. | 21403 | | | | |
| | | 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of Competing), gramatory of other place) 20c. LOCATION — City or Town, State | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. | | | | | | | | | | | |
| | Zanny H-Roose | | | WEST ST. | | | | 101 | | | | |
| | 23. PART t. Enter the diseases, or complications that caused the de | eeth. Do not | | | | | | Approximate | | | | |
| | ahock, or heart failure. List only one cause on each line IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSE | A - | | | | | | Interval Between Onset and Death 5 DAYS | | | | |
| z | CONCESTIV | OUENCE OF): | HEAR | T /2 | 1/64 | 10 | | DAVI | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST | US/0 | 2 | | | | | YGAN | | | | |
| S | d | | | | | | | | | | | |
| : MEDICAL | PART II. Other algorithms conditions contributing to death but not DEHENTIA PERIPHERAL SACRAC DECUBITUS PEPT. ANEMIA DIVERTICULTIS | VASC | LCEA | 7.3 | 150- 10 | . WAS AN AUTO PERFORMED YES 2 |)? | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | HNET | | ACE OF DEATH (Che | eck only one) | | | | | | | |
| Sic | EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 ER/Outpatient 3 | | THER: Nursing Horn | e 5 Residence | 6 Other (Spi | ecify) | | | | | | |
| | 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) | 28b. TIME (| | URY AT | 28d. DESCRIE | E HOW INJUR | RY OCCURED | | | | | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | | | rES 2 NO | | | | | | | | |
| | 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At he building, etc. (Specify) | ome, ferm, stre | et, fectory, offic | • | 28f. LOCATION City or Tox | | Number or Rural F | Route Number, | | | | |
| COMPLET | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the beet of my knowledge, do not not not not not not not not not no | | | | | | | | | | | |
| | 296. SIGNATURE AND TITLE OF CENTURE | // | my opinion, c | | | | | | | | | |
| TO BE | Jun / Swo | for | | DO 18 | 89 | 296 | d. DATE SIGNED | (Month, Day, Year) | | | | |
| | 30. NAME AND ADDRESS OF PERSON WHI COMPLETED CAUSE OF DEATH (ITE | M 27) (Type, Pr | 11 4. | 2 | | 7. | 4 | More- dlady | | | | |
| | 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE | 205 | HOPKIN | US WAYU | iem (| 1/2-1 | GALTI | YUNG- dlady | | | | |
| | ALIC OO 1004 | 4 | | | | | | | | | | |

OHMH-16 Rev 1/89



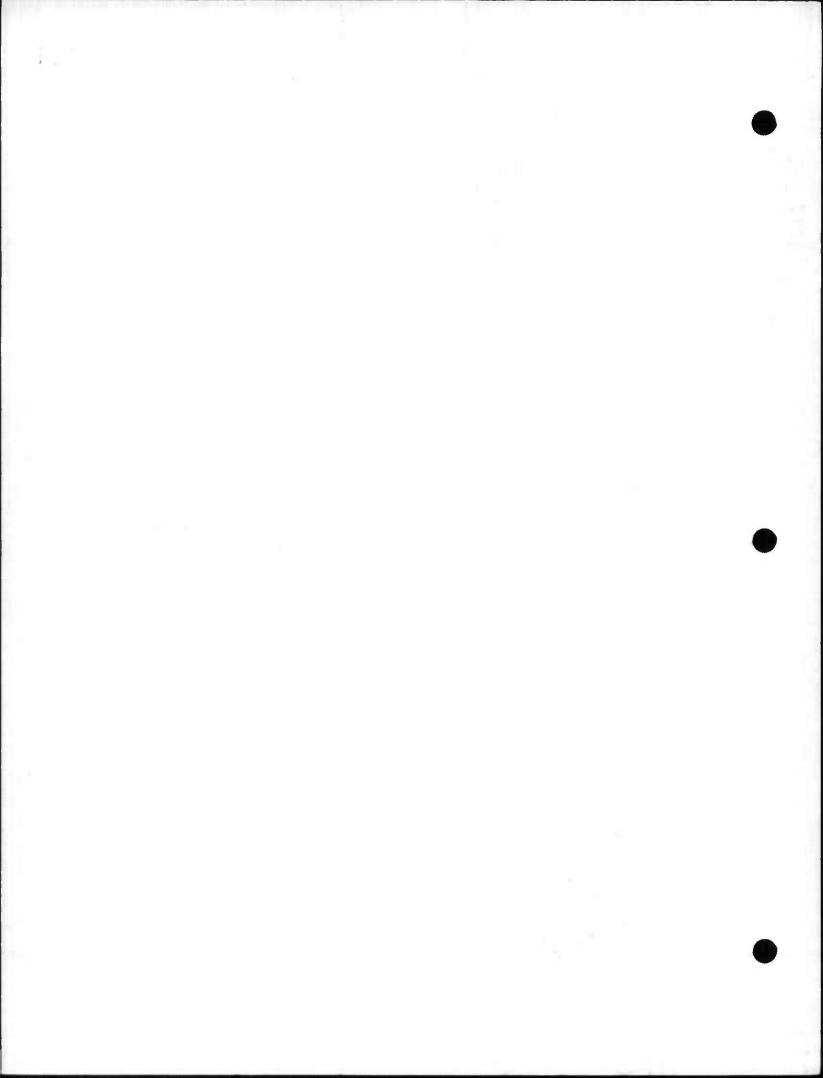
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| 1 - STATE REGISTRAR | | CERTIFIC | CATE OF | DEATH | REG. I | 10. | | |
|--|--|--|---------------------|------------------------|---|----------------------|--------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Las. | " Sadye Au | igusta T | urner | | 2, DATE OF DEATH | DAY | YEAR | 3. TIME OF DEATH |
| Sadye | M | | mer | | 08 | 17 | 94 | 4:15 Pm |
| 4. SOCIAL SECURITY NUMBER | | _ | F UNDER 1 YEAR | IF UNDER 24 HRS, | 7. DATE OF BIRTH (Month, Day, Year | | 8. BIRTH Countr | PLACE (State or Foreign |
| 226-01-9848 | | 101 YRS. | DATE DATE | NOOKS WIN. | June 24, | | | ginia |
| 9a. FACILITY NAME (If not institution, give | street and number) | | b. CITY, TOWN | OR LOCATION OF DE | ATH | 9c. COL | INTY OF D | EATH |
| Wicomico N RESIDENCE OF DECEDENT | hursing Home | | Sal | isbury | | | Wi | comico |
| 10a. STATE 10b. COUN | | 10c. CITY, | TOWN OR LOCA | TION | | | | 10d. INSIDE CITY |
| Maryland Wi | icomico | Sal | lisbury | | | | | LIMITS? |
| 100. STREET AND NUMBER 413 Loblolly La | ane | • | 10 | 1. ZIP CODE 2 180 1 | | | JSA | WHAT COUNTRY? |
| 11. MARITAL STATUS | 12. WAS DECEDENT EVER FORCES? 1 YES | | | CENDENT OF HISPAN | | Yea or No- | 14. RACE | — American Indian, |
| 1 Never Married 2 Married 3 X Widowed 4 Divorced | IF YES, GIVE WAR OR | | | S 2 🔀 NO Specify | | | Speci | |
| 15. DECEDENT'S EL (Specify only highest gre | DUCATION de completed) | 16a. DECEDENT'S US (Give kind of woo | rk done during m | | 16b. KIND OF | BUSINESS/IN | DUSTRY | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use | | | | | | |
| 12 17. FATHER'S NAME (First, Middle, Last) | 3 | Secreta | ry | T | | | | |
| | McCarroll | | | Minnie | ME (First, Middle, Mail (unk) | | ybea | 1 |
| 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING A | DDRESS (Street | and Number or Rural F | oute Number, City or | Rown, State, Z. | (p Code) | |
| John C. Turner | Jr. | 413 Lo | blolly | Lane, Sa | lisbury, | MD 2 | 1801 | |
| 20e. METHOD OF DISPOSITION 1 | moval from State | b. PLACEAND DATE OF meters, cremetory or other Salisbury C | rematory | | 8/19 | LOCATION - Salisb | | |
| 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE | | | oway Fune | | 1 | W | D 21001 |
| 23 PART i. Enter the disesses, o | 00 | ed the death. Do no | | Snow Hill | | | | |
| shock, or heart failure | e. List only one cause on | each line. | t enter the m | ode of dynig, such | r as cardiac or re | spiratory si | rest, | Approximate interval Between |
| IMMEDIATE CAUSE (Final disease or condition | Com | ten. | 6011 | f () . | | | | Onset and Death |
| reaulting in death) | a. DUE TO (OR AS | A CONSEQUENCE OF | 0010 | 11111 | | | | חומטו |
| | a. COND DUE TO (OR AS | 7409 | an 1 | en n | 1 - | | | 200 |
| Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS | A CONSEQUENCE OF): | 1011 | | 1 | | | 1/22 |
| csuse. Enter UNDERLYING | C. | Bre | | | | | | |
| CAUSE (Disease or injury that initiated events | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | | |
| resulting in desth) LAST | d | | | | | | | |
| PART II. Other significant condition | ons contributing to death | but not resulting in | the underlyin | n cause given in | Part i 24a WMS | AN AUTOPSY | 245 | WERE AUTOPSY FINDINGS |
| Venil | | | and andonya | g codec given in | PER | ORMED? | 240 | AMILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | 1 YES | 2X NO | | OF DEATH? |
| | | | | | - | | | 1 TES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL | | | 26. P | LACE OF DEATH (Che | ck ank one) | | | |
| EXAMINER? 1 Tes 2 To No | HOSPITAL: 1 Inpatient 2 ER/Out | Instignt 3 DOA | OTHER: | ne 5 🗆 Residence | | | | |
| 27. MANNER OF DEATH | 28e. DATE OF INJURY | 26b. TIME | OF 28c. IN | JURY AT | 28d. DESCRIBE HO | W INJURY OC | CURED | |
| 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJUR | | ORK? YES 2 NO | | | 41 | |
| 3 Suicide 6 Could not b | 26a PLACE OF IN HIS | Y — Al home, farm, atre | eat, factory, offic | ia . | 261. LOCATION (Str. City or Town, St | | or Or Rural F | loute Number, |
| 4 Homicide determined | | | | | | , | | |
| (Check only 1 CERTIFYING PHY | SICIAN: To the best of my know | wledga, death occurred | at the time, det | and place, and due | to the cause(a) and | manner as ate | rted. | |
| one) 2 MEDICAL EXAMI | NER: On the beals of examination | on and/or investigation, | In my opinion, | death occured at the | time, data and place | and due to t | he cause(s |) and manner as stated. |
| 296. SIGNATURE AND THE OF CERTIF | IER | | | 29c. LICENSE NUM | BER | 29d. DA | TE SIGNED | (Month, Day, Year) |
| 1-00 | | 7 | | D02026 | 5 | • | 08/19 | 9/94 |
| 30. NAME AND ADDRESS OF PERSON V | VHO COMPLETED CAUSE OF D | EATH (ITEM 27) (Type, P. | rint) | | | | | |
| F.G. Arthes. 31. DATE FILED (Month, Day, Year) | | cean Pines | s, Berl | in, Md. | 21811 | | | |
| AUC 23 199 | 32. REGISTRAR'S SIG | NATURE | | | | | | |
| ~ ~ 0 133 | 17 Java ariula | worklandall | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

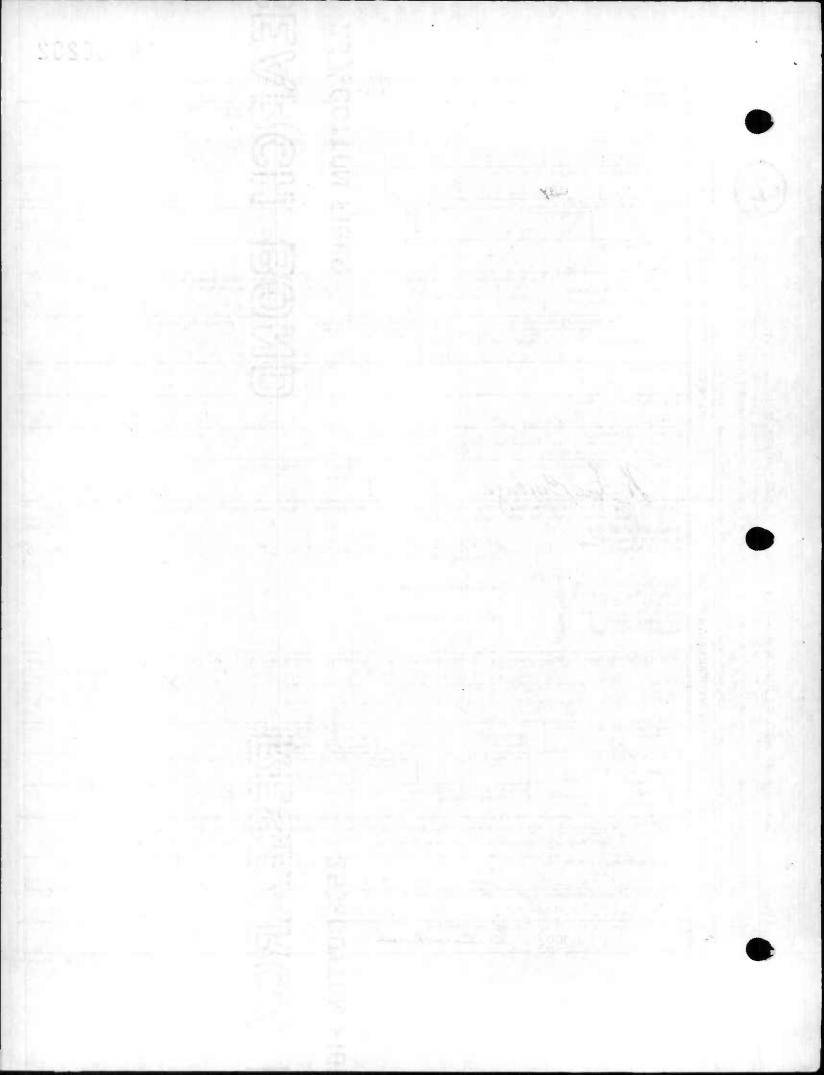
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



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| | | other traumatic event. the medical examiner must be notified at once |
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| FOR 1 - STATE REGISTRAR | STATE OF MARYL | | MENT OF HEAD | | ENTAL HYGIEN | E | | | | | |
|--|--|----------------------|--|-----------------|---|-------------------|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Frances Ma | artha (Harmon | | | | 2. DATE OF DEATH DA | Y YEAR | 1 5 · 50 A | | | | |
| 4. SOCIAL SECURITY NUMBER 212-74-6618 | 1 🗆 M 2 😡 F | | F UNDER 1 YEAR IF | - | 7. DATE OF BIRTH (Month, Day, Year) 7/15/04 | A. BIR | 8. BIRTHPLACE (State or Foreign Country) MD | | | | |
| 90. FACILITY NAME (If not institution, 12611 E. Torque | ay Rd. | 9 | Ocean C | | Н | Worce: | | | | | |
| 10e, STATE 10b, Co | orcester | 10c. CITY, 1 | rown or location | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | | | | |
| 10e. STREET AND NUMBER 32 Burley St. 11. MARITAL STATUS | | | 101, ZIP | CODE 811 | | 10g. CITIZEN OF | F WHAT COUNTRY? | | | | |
| 3 CWidowed 4 Divorced | 12. WAS DECEDENT EVER IF FORCES? 1 TYES IF YES, GIVE WAR OR D | 2 NO | 13. WAS DECENDED If yes, specify 1 YES 2 | Cuban, Maxican, | ORIGIN? (Specify Yes Puarto Rican, etc.) | Bi | CE — American Indian, ack, White, atc. ecity: White | | | | |
| 15. DECEDENT'S (Specify only highest Elementary/Secondary (0-12) 8 17. FATHER'S NAME (First, Middle, Last | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refired.) 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | | |
| unknown | 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) | | | | | | | | | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Matthews 12611 E. Torquay Rd. Berlin, MD 21811 | | | | | | | | | | |
| | 20a. METHOD OF DISPOSITION 1 Deurial 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE Of DISPOSITION (Name of Specify) 20c. LOCATION — City or Town, State Springfull Cemetery 8/26/94 Girdletree, MD | | | | | | | | | | |
| 21. SIGNATURE OF TUNESUS SERVI | 22. NAME AND ADDRESS OF FACILITY Burbage Funeral Home 108 William St., Berlin, MD 21811 | | | | | | | | | | |
| 23. PART I. Enter the diseases shock, or heart fall IMMEDIATE CAUSE (Final disease or condition resulting in death) | disease or condition | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| PART II. Other algnificent con | ditions contributing to deeth b | out not resulting in | the underlying ca | usa given in Pa | 24a. WAS AN PERFOR | MED? | 4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | |
| 25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | | | 28. PLACE | OF DEATH (Check | k only one) | | | | | | |
| EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | HOSPITAL: 1 Inpatient 2 ER/Out | | THER: Nursing Home 5 28c. INJURY | - | | | | | | | |
| 2 Accident investig | (Month, Day, Year) | AULMI | WORK? | 2 🗌 NO | ed. DESCRIBE HOW I | | 10. | | | | |
| 3 Suicide 6 Could n 4 Homicide determine | building, etc. (Spe | city) | et, factory, office | | (81, LOCATION (Street a City or Town, State) | ind Number or Hun | al Houte Number, | | | | |
| | PHYSICIAN: To the bast of my know AMINER: On the basis of examination | | | | | | e(s) and manner as stated. | | | | |
| 29b. SIGNATURE AND TITLE OF CEP | ~/ | M.D | . 15 | O30 | | | ED (Morth, Day, Year) 3 - 23 1994 | | | | |
| James E. | Mar +: n M. | D. 1495 | E. 6 | -10/1 | 77.,5 | 1:350 | n, MD. | | | | |
| AUG 241 | 994 Juli Seri | con- President | | | | | DHMH-18 Rev 1/6 | | | | |

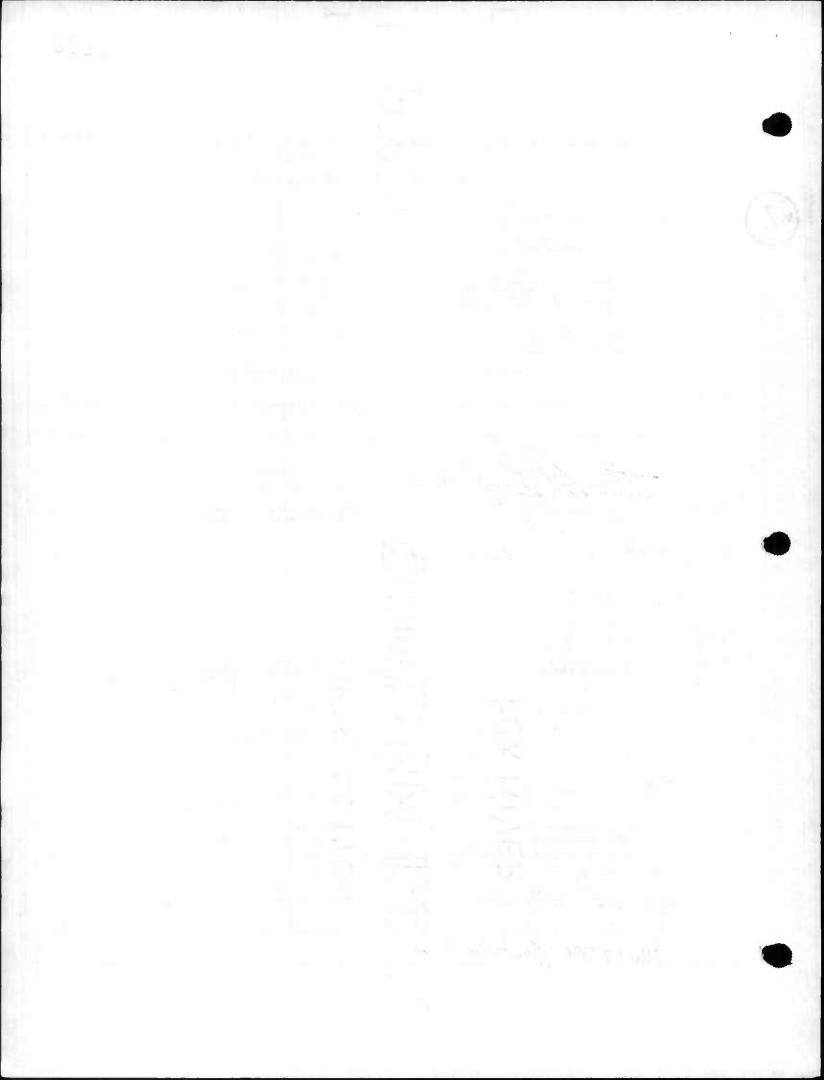


1 - FOR STATE REGISTRAR

| 68760, | |
|----------|--|
| . BOX 68 | |
| P.0 | |
| RECORDS | |
| OF VITAL | |
| DIVISION | |

| | 1. DECEOENT'S NAME (First, Middle, Last | | - | | | 2. DATE OF DEATH | DAY Y | 3. TIN | ME OF DEATH | | | |
|--|--|--|---|--|--|---|---|------------------------|--|--|--|--|
| | tatrick | Henry | 00 | IV | | August | | 4 | 6:10 4 | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | (In yrs. last birthde | MONTHS | YEAR IF UNDER 24 HRS. DAYS HOURS MIN. | 7, DATE OF BIRTH (Month, Day, Year) | | BIRTHPLACE Country) | (State or Foreign | | | |
| | 240-20-9176 | | 73 YRS | S. | | January 6.1 | | | arolina | | | |
| | 9a. FACILITY NAME (If not institution, give Charlotte Hall V | · · | | | TOWN OR LOCATION OF I | | 9c. COUNTY | | | | | |
| Dinection | RESIDENCE OF DECEDENT | eterans nome | 3 | Cna | rlotte Hal | 1 | St. Mary's | | | | | |
| | 10a. STATE 10b. COUN | ТҮ | 10c. | CITY, TOWN OF | LOCATION | | | 10d. J | INSIDE CITY | | | |
| | | Mary's | | Lexing | ton Park | | Linconnection | | | | | |
| ٤ | 10e. STREET AND NUMBER | | | | 101. ZIP CODE | | OF WHAT C | COUNTRY? | | | | |
| FUNERAL | Route 3, Box 63 | 12. WAS DECEDENT EVER | IN II S ARMED | 19 W | 20653 | MIC OBIGIN2 (Specify V | United United United | | | | | |
| | 1 Never Married 2 🔀 Married | FORCES? 1 X YES | S 2 NO | i ir | yes, specify Cuban, Mexic ☐ YES 2 🔯 NO Specific | an, Puerto Rican, etc.) | nn, Puerto Rican, etc.) Black, | | | | | |
| ē | 3 Widowed 4 Divorced | WWII | | | | .,, | 1 1 | Black | | | | |
| | 15, DECEDENT'S ED (Specify only highest grad | | (Give kind | of work done do | CUPATION uring most of working | 16b. KIND OF B | USINESS/INDUS | TRY | | | | |
| COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | Labor | OT use retired.) | | Defen | 60 | | | | | |
| | 8 17. FATHER'S NAME (First, Middle, Last) | <u> </u> | Labor | rer | 18. MOTHER'S N | AME (First, Middle, Maide | _ | | | | | |
| ם כ | Wright Toon | | | | Emma L | | | | | | | |
| 00 | 10s INFORMANT'S NAME (Small Print) | | | | | | | | | | | |
| 2 | Mary E. Toon | | Rout | e 3. B | ox 63. Lex | ington Par | k. Mary | rland | 20653 | | | |
| | 20e. METHOD OF DISPOSITION 1 A Burdal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place) | | | | | | | | | | | |
| 4 Doneston S Ser (Specify) Iaryland Veterans Cemetery Cheltenham, N 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | | | |
| | (dillet) | 1. Dung | \mathcal{X} | | insfield F | | e | | | | | |
| - 1 | Edward N. Br | | | | 0. Box 279 | Leonardt | own. Ma | rvlan | d 2065 | | | |
| | 23. PART i. Enter the disease, or compilections that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feliure. List only one cause on each line. | | | | | | | | | | | |
| | IMMEDIATE CAUSE (Final | | | | | | | | Onset and D | | | |
| | disease or condition a. PALVMOHIM BUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| _ | | | | | | | | | | | | |
| <u>ة</u> | Sequentielly list conditions, if any, leading to immediate | | A CONSEQUENC | E OF): | | | | | year. | | | |
| S | cause. Enter UNDERLYING CAUSE (Disease or injury | C | | | | | | | | | | |
| RTIFICATION | that initiated events resulting in deeth) LAST | DUE TO (OR AS | A CONSEQUENC | E OF): | | | | | | | | |
| 병 | | d | | - | | | | | | | | |
| | PART II. Other eignificent condition | one contributing to death | but not resulti | ing in the und | derlying ceuse given i | n Part I. 24a. WAS A | N AUTOPSY DRMED? | AVAIL | AUTOPSY FINDI | | | |
| EDICAL | CVA | | _ | | | 1 YES | 2 ANO | | PLETION OF CAU EATH? | | | |
| | h49हर | TENSION | | | | | | 1 🗆 | | | | |
| ≅ | | | | | | | | | | | | |
| ≥ | 25 WAS CASE DECEDDED TO MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) | | | | | | | | | | |
| ≅ | EXAMINER? | HOSPITAL: | attend 2 - DO | OTHER | : | | | | YES 2 NO | | | |
| SICIAN: M | | 1 - Inpetient 2 - ER/O | Y 28b. | TIME OF | ing Home 5 Residence | | / INJURY OCCU | REO | YES 2 NO | | | |
| PHYSICIAN: M | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending | 1 Inpatient 2 ER/Or 28a. DATE OF INJUR (Month, Day, Year | Y 28b. | A 4 Nure | : Ing Home 5 🗆 Rasidenc | 6 Other (Specify) | INJURY OCCUI | REO | YES 2 NO | | | |
| D BY PHYSICIAN: M | EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending investigation 2 Accident investigation 3 Suicide 8 Could not be | 1 Inpatient 2 ER/O | Y 28b. | TIME OF INJURY | ing Home 5 Residence 28c. INJURY AT WORK? 1 YES 2 NO | 6 Other (Specify) 28d. DESCRIBE HOW | t and Number or | | | | | |
| ED BY PHYSICIAN: M | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 1 Inpatient 2 ER/Oc 28a. DATE OF INJUR (Month, Day, Year | Y 28b. | TIME OF INJURY | ing Home 5 Residence 28c. INJURY AT WORK? 1 YES 2 NO | 6 Other (Specify) 28d. DESCRIBE HOW | t and Number or | | | | | |
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| ED BY PHYSICIAN: M | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER Check only | 28e. PLACE OF INJUR 28e. PLACE OF INJUR 28e. PLACE OF INJUR building, etc. (S) | Y 28b. RY — At home, fe occify) | OA 4 Nursi | ing Home 5 Residence 26c. INJURY AT WORK? 1 YES 2 NO wry, office | 28d. DESCRIBE HOW 28d. LOCATION (Stree City or Town. Ste | et and Number or te) | Rural Route A | Humber, | | | |
| E COMPLETED BY PHYSICIAN: M | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER Check only | 28a. DATE OF INJUR (Month, Day, Year 28a. PLACE OF INJUR 28a. PLACE OF INJUB building, etc. (S) YSICIAN: To the best of my kn NER: On the basia of axaminar | Y 28b. RY — At home, fe occify) | OA 4 Nursi | ing Home 5 G Rasidence 28c. INJURY AT WORKY 1 G YES 2 NO Interpretation of the control of the co | 28d. DESCRIBE HOV 28d. LOCATION (Stree-City or Town, Ste us to the cause(s) and meetime, data and place, UMBER | it and Number or le) nanner as stated and due to the o | Rural Route M | Number, manner as state th, Day, Year) | | | |
| BE COMPLETED BY PHYSICIAN: M | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMI | 28a. DATE OF INJUR 28a. DATE OF INJUR (Month, Day, Year 28a. PLACE OF INJU building, etc. (S) YSICIAN: To the best of my kn INER: On the basis of examinar TIER | PY — At home, fa pocify) aviedge, death oc tion and/or investig | TIME OF INJURY M rm, street, factor coursed at the tir getton, in my of | ing Home 5 Residence 28c. INJURY AT WORK? 1 YES 2 NO iny, office me, data and place, and dispinion, death occurred at ti | 28d. DESCRIBE HOV 28d. LOCATION (Stree-City or Town, Ste us to the cause(s) and meetime, data and place, UMBER | it and Number or le) nanner as stated and due to the o | Rural Route M | Number, manner as state th, Day, Year) | | | |
| COMPLETED BY PHYSICIAN: M | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident 6 Could not be determined 29a. CERTIFIER (Check only 0 MEDICAL EXAMI) 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON V | 28a. DATE OF INJUR 28a. DATE OF INJUR (Month, Day, Year 28a. PLACE OF INJU building, etc. (S) YSICIAN: To the best of my kn INER: On the basia of examinar TIER WHO COMPLETED CAUSE OF | Y 28b. RY — At home, faceocity) owledge, death oction and/or investig | TIME OF INJURY M rm, street, facto curred at the tir gation, in my of | ing Home 5 Residence 28c. INJURY AT WORK? 1 YES 2 NO or, office The data and place, and distribution, death occurred at the second seco | 28d. DESCRIBE HOW 28d. DESCRIBE HOW 28f. LOCATION (Stree City or Town. Sta | t and Number or tenner as stated and due to the c | Rural Route A | manner as state h, Day, Year) | | | |
| BE COMPLETED BY PHYSICIAN: M | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident 6 Could not be determined 29a. CERTIFIER (Check only 0 MEDICAL EXAMI) 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON V | 28a. DATE OF INJUR 28a. DATE OF INJUR (Month, Day, Year 28a. PLACE OF INJU building, etc. (S) YSICIAN: To the best of my kn INER: On the basia of examinar TIER WHO COMPLETED CAUSE OF | Y 28b. RY — At home, faceocity) owledge, death oction and/or investig | TIME OF INJURY M rm, street, facto curred at the tir gation, in my of | ing Home 5 G Rasidence 28c. INJURY AT WORKY 1 G YES 2 NO Interpretation of the control of the co | 28d. DESCRIBE HOW 28d. DESCRIBE HOW 28f. LOCATION (Stree City or Town. Sta | t and Number or tenner as stated and due to the c | Rural Route A | Number, manner as state | | | |
| BE COMPLETED BY PHYSICIAN: M | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 30. NAME AND ADDRESS OF PERSON VI | 28a. DATE OF INJUR 28a. DATE OF INJUR (Month, Day, Year 28a. PLACE OF INJU building, etc. (S) YSICIAN: To the best of my kn INER: On the basia of examinar TIER WHO COMPLETED CAUSE OF | Y 28b. RY — At home, faceocity) owledge, death oction and/or investig | TIME OF INJURY M rm, street, facto curred at the tir gation, in my of | ing Home 5 Residence 28c. INJURY AT WORK? 1 YES 2 NO or, office The data and place, and distribution, death occurred at the second seco | 28d. DESCRIBE HOW 28d. DESCRIBE HOW 28f. LOCATION (Stree City or Town. Sta | t and Number or tenner as stated and due to the c | Rural Route A | manner as state th, Day, Year) | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



| BALTIMORE, MARYLAND 21215-0020 | 4 nours after death. Page 6 may be retained by the hospital or attending physician | filled in by the funeral director, page 5 should be detached for use as the burial-time, or removal. | e medical examiner must be notified at once. |
|--|--|---|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-ten be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| 1 | | FOR STATE REGISTR | AR |
|---|------|-------------------------|----|
| | 1. D | ECEDENT'S | NA |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| _ | REGISTRAR | | CERTIF | ICATE C | F DEATH | REG. I | VO. | | | |
|----------------------|--|---|---|---|-------------------------------------|---|----------------------|-------------------------------------|---|--|
| | DECEDENT'S NAME (First, Middle, Last) | Hilda P. | Taggar | t | | 2. DATE OF DEATH MONTH August | 28, 199 | year 94 (| 0715 M | |
| | 4. SOCIAL SECURITY NUMBER 199-05-4799 | 5. SEX 6. AGE | (In yrs. last birthday) 92. YRS. | IF UNDER 1 YEA | | 7. DATE OF BIRTH (Month, Day, Year Aug. 7, | , | BIRTHPLACE (S Country) Pennsy | State or Foreign | |
| OR | So. FACILITY NAME (If not institution, give st Laurelwood Nursi | | | 96. CITY, TOV Elkt | On Location of D | | | TY OF DEATH | | |
| 5 | RESIDENCE OF DECEDENT | | | | | | | | | |
| FUNERAL DIRECTOR | Maryland Ceci | | | kton | CATION | | | LIN | SIDE CITY AITS? ES 2 NO | |
| VERAL | 100. STREET AND NUMBER 100 Laurel Drive | | | | 101. ZIP CODE 21921 | | | EN OF WHAT CO | UNTRY? | |
| B | ti. MARITAL STATUS t Never Married 2 Married 3 Nuldowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I | 2 X NO | If yes | , specify Cuban, Maxico | NDENT OF HISPANIC ORIGIN? (Specify Yea or No— lfy Cuben, Maxican, Puerto Rican, etc.) 2 NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| COMPLETED | 15. OECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | | 16a. DECEDENT'S (Give kind of a life. Do NOT us | USUAL OCCUP work done during se retired.) | ATION most of working | 16b. KIND OF | BUSINESS/INDU | STRY | | |
| MPL | 9 17. FATHER'S NAME (First, Middle, Last) | | Owner/H | urnitu | re Stores | Retai | | | | |
| BE CC | T. Hoffma | in | | | 18. MOTHER'S NA | Emily O | | | | |
| 5 | 190. INFORMANT'S NAME (Type/Print) Agnes R. Lobach | | P.O. | Box 12 | et and Number or Rural 96 - Elkt | Route Number, City or On, MD 2 | Town, State, Zip (| Code) | | |
| | 20s, METHOD OF DISPOSITION 1 A Burlel 2 Cremation 3 Remo 4 Donation 8 Other (Specify) | oval from State 20 | b. PLACE AND DATE (Petery, cremetory or a temperature) | of Disposition | (Name of eption Cer | 8°-31 20c. | | ity or Town, State | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | 2 11. 1- | | 10 | AND ADDRESS OF FACES Home | ockton St | reet | | | |
| | 23. PART i. Enter the diseases, or c shock, or heart fellure. I IMMEDIATE CAUSE (Final disease or condition resulting in death) | Liat only ona cause on a | aach iina. | | | | | in | pproximata tarval Between neet and Daeth 2 WK | |
| EDICAL CERTIFICATION | disease or condition resulting in death) Fever most likely 2 Asymisation Brinchopmens 2 with Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Fever most likely 2 Asymisation Brinchopmens 2 with Sequence of: Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | |
| AL C | PART ii. Other algnificant conditions | s contributing to death | but not reaulting | In the underl | ying cause given in | | AN AUTOPSY ORMED? | | JTOPSY FINDINGS LE PRIOR TO | |
| | | | | | | 1 | 2 NO | COMPLE OF DEAT | TION OF CAUSE | |
| PHYSICIAN: M | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Out | patient 3 DOA | OTHER: | PLACE OF OEATH (Ch | | | | | |
| ву рну | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIM | E OF 28c. | INJURY AT WORK? YES 2 NO | 28d. DESCRIBE HO | W INJURY OCCU | JRED | | |
| | 3 Suicide 8 Could not be determined | 28e. PLACE OF INJUR building, etc. (Spe | Y — Al home, ferm, s cdfy) | streel, factory, o | ffica | 28f. LOCATION (Stre City or Town, St | | r Rural Route Num | ber, | |
| 7 1 | 29a. CERTIFIER 1 CERTIFYING PHYSIC | CIAN: To the best of my know | riedge deeth occurr | of at the time | late and place and d | to the secondary | | | | |
| COMPLETED | one) 2 MEDICAL EXAMINER | R: On the besis of examination | | | n, death occured at the | lime, data and place, | | | nner sa stated. | |
| TO BE | | C. Perlor M | | | 29c. LICENSE NUI | | 29d. DATE | SIGNEO (Month, E | hey, Year) | |
| | Jaynatilal K. Pa | tel, M.D | 123 Sing | erly A | venue - El | lkton, MD | 21921 | | | |
| | 31. DATE FILED (Month, Day, Year) SEP 07 1994 | 32. REGISTRANS SIGN | LADIT RONSOLL | | | | | | | |

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director, page 5 should be detached

ITEMS: 23 PART I, 27, PER MEO FILM G-715 9/15/94 t.t FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR **CERTIFICATE OF DEATH** 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR GEORGE WILLIAM TALBOT 19 94 2153 AUG. PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIFTH 8. BIRTHPLACE (State or Foreign 004-50-8525 MONTHS DAYS HOURS ochemin 26 1947 46 YRS. 1 🔯 M 2 🗌 F Maine 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c, COUNTY OF DEATH GARRETT GARRETT MEMORIAL HOSPITAL OAKLAND RESIDENCE OF DECEDENT Os. STATE 18c. CITY, TOWN OR LOCATION W. Va. Preston Terra Alta t YES 2 NO 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Rt 1 Box 5B 26764 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 TES 2 TNO Specify: 3 Widowed 4 Divorced Vietnam Era White 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) Garage (Car) 8 Mechanic & Welder 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Irving Talbot, Sr. Frances Wheatley 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances McDonald Rose Acres Apt. B3 Caribou, Maine 04736 20s. METHOD OF DISPOSITION
1 💥 Burlel 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Terra Alta Cemetery 4 Donation 5 Other (Specify) 8-23-94 Terra Alta, W.Va 21. SIGNATURE OF FUHERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Arthur H. Wright Funeral Home, Inc. arthur Wright 105 Highland Ave. Terra Alta, WV 23. PART I. Enter the disesses, or complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heert feilure. List only one cause on each line. interval Between **IMMEDIATE CAUSE (Finei Onset and Death** disesse or condition CARDIAC ARRHYTHMIA resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in deeth) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY PHIDOUGS AWAR ARREST PRINCIPLES COMPLETION OF CAUSE OF DEATH? YES 2 NO 1 TYES 2 MO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 75. WAS CASE REFERRED TO MEDICAL 26 PLACE OF DEATH /C/w EXAMINERS HOSPITAL: OTHER XXES 2 NO ome 5 🗆 Residence 6 🗀 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJUSTY 286. TIME OF 28c. INJURY AT WORK? 264. DESCRIBE HOW INJURY OCCURED 1 EX Natural t ☐ YES 2 ☐ NO 2 Accident 29e. PLACE OF INJURY - At home, farm, street, factory, office 3 Suicide 281. LOCATION (Street and Number or Rural Route Number ft Could not be 4 | Homicide 29s. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. on and/or Investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and matter as stated

29c. LICENSE NUMBER

O.C.M.E

after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760, OR ATTENDING PHYSICIAN: THE FUNERAL D filed within 72 hc HOSPITAL. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II

> MD111 Penn Street, Baltimore, Maryland 21201 31. DATE FILED (Month, Day, Year) AUG 2 9 19 22. REGISTRAR'S SIGNATURE lia Develor Ros

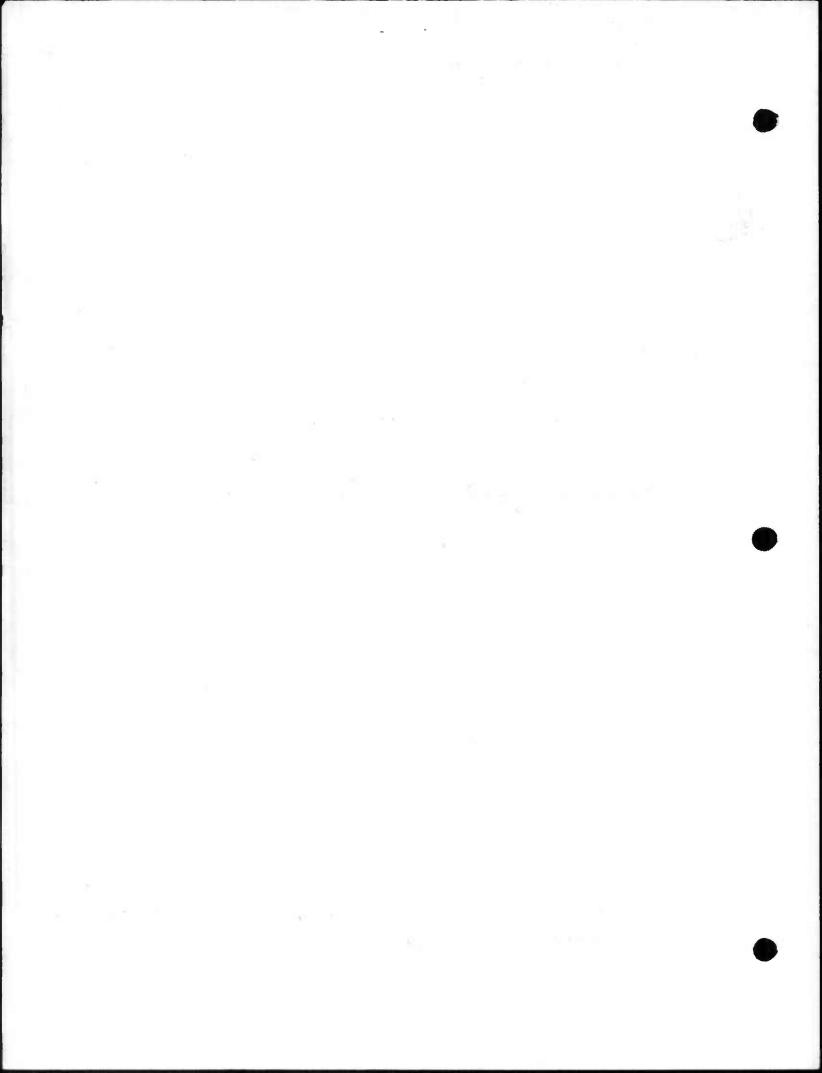
GOL

USE OF DEATH (ITEM 27) (Type, Point)

SIGNATURE AND TITLE OF CENTURER

29d. DATE SIGNED (Month, Day, Year)

▶ AUG. 20,1994



x death. Page 6 may be retained by the hospital or attending physician. The forest permit. Pages 1, 2, 3 should be funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

| DALLIMORE, MARTLANI | cuted within tours after death. Page 6 may be retained by the hos | d completely filled in by the funeral director, page 5 should be detacht urial, cremation, or removal. | ilc event, the medical examiner must be notified at once. |
|--|---|--|--|
| DIVISION OF VILAE RECORDS, F.O. BOX 68/60, | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within cours after death. Page 6 may be retained by the hos | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First | t, Middle, Last) | | | | | | | | 2. DATE OF DEATH | | | 3. TIME OF DEATH |
|---------------|---|--------------------------|---------------------------|---------------------|-------------|---------------|-------------|---------------|-----------|--|--|-----------------|--|
| | Hannah D. Tharp | | | | | | | | | | | | |
| | 4. SOCIAL SECURITY NUM | BER | 5. SEX | 6. AGE (in yrs. les | l birthday) | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF BIRTH | | 8. BIRTI | HPLACE (State or Foreign |
| - 3 | 188-16-75 | 26 | 1 M 2 X F | 74 | YRS. | MONTHS | DAY8 | HOURS | MIN. | Aug. 29, 1 | 919 | Che | ster, PA |
| | 9a. FACILITY NAME (If not is | nstitution, give | atreet and number) | | | 9b. CITY | , TOWN | OR LOCATI | ON OF DI | | _ | UNTY OF E | |
| 5 | 925 Secur | | | Ha | gers | town | | | Was | shington | | | |
| 3 | RESIDENCE OF DE | | | | | 1 | | | | | | | |
| DIRECTOR | 10a, STATE | 10b. COUN | | | 10c. CIT | ry, town (| OR LOCA | TION | | | | | 10d. INSIDE CITY LIMITS? |
| | PA | York | 2 | | Sh | rews | | | | | | | 1) YES 2 NO |
| 3AL | 100. STREET AND NUMBER 29 Valley | | | | 10 | . ZIP COD | | | 10g. Cf | | WHAT COUNTRY? | | |
| FUNERAL | | поац | | | | | | | 173 | | | USA | |
| F | 11. MARITAL STATUS 1 ☐ Never Married 2 反 | Married | 12. WAS DECEDEN | TEVER IN U.S. AR | MED | 13. | WAS DEC | ENDENT (| OF HISPAI | NIC ORIGIN? (Specify Your, Puerto Rican, etc.) | es or No— | 14. RAC Bloc | E — American Indian, k, White, atc. |
| ВУ | 3 Widowed 4 Div | | IF YES, GIVE | MAR OR DATES | | | | | y: | | Spec | White | |
| ED | 15. DEC | EDENT'S ED | UCATION | 16a. DE | CEDENT'S | USUAL O | CCUPATI |)N | | 16b. KIND OF BI | ICINESS/IN | IDIISTRY | |
| TE | (Specify on | ly highest gred | le completed) | (G | ive kind of | work done | during mo | st of working | ng | IBB. KIND OF BI | JOINE JOIN | DOSINI | |
| 7 | Elementary/Secondary (| 0-12) | College (1-4 or 5 | | cret | arv | | | | Insurance Compan | | | anv |
| COMPLET | 17. FATHER'S NAME (First, A | Aiddle, Last) | _ | 1 20 | 0100 | ar y | | 18. MOT | HER'S NA | ME (First, Middle, Malde | | | |
| E | Albert B. | Smith | 1 | | | Flossie A. Ku | | | | | | | |
| 0 | 19a. INFORMANT'S NAME | Type/Print) | | 191 | b. MAILING | ADDRES: | S (Street i | | | Route Number, City or To | | In Code) | |
| 2 | Grover J. | Tharp | | | 29 V | alle | y Ro | ad. | Shre | wsbury, P. | A 1 | 7361 | |
| | 20g. METHOD OF DISPOSIT | TION | | 20b. PLACE | | | | | | DATE 20c. L | OCATION - | - | own, Sieta |
| | 1 X Burial 2 Crematic 4 Donation 6 Other | | moval from State | - Glen | | | | amat | Au | g. 26, 1994 | G1 | en R | ock, PA |
| | 21. SIGNATURE OF FUNERA | AL SERVICE L | ICENSER? | a a | HOCK | | | ID ADDRE | | CILITY | | | |
| - 3 | > hee | 181 | 1 de | call | | | Gei | ple | Fune | ral Home, | Inc. | | |
| | 53 Main St. Glen Rock. PA 17327 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate | | | | | | | | | | | | |
| CERTIFICATION | disease or condition resulting in desth) a. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in desth) LAST DUE TO (or as a consequence of): DUE TO (or as a consequence of): | | | | | | | | | | | | |
| MEDICAL | PART II. Other significa | deeth but not r | resulting | In the ur | nderiyin | g cause | given in | | RMED? | 248 | D. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| IA | 25. WAS CASE REFERRED T | O MEDICAL | | | | | 26. P | ACE OF D | EATH (Ch | eck only one) | | | |
| SIC | EXAMINER? | | HOSPITAL: | ☐ ER/Outpetlant 3 | □ DOA | OTHEI | R: | U. v a | - | 6 Other (Specify) | | | 1000 |
| PHYSICIAN: | 27. MANNER OF DEATH | | 26a. DATE Of (Month, I | | 28b. TIN | AE OF | 28c. IN. | URY AT | | 28d. DESCRIBE HOW | INJURY O | CCURED | |
| ВУР | | Pending Investigation | | July, rour) | " | JURY M | | YES 2 | NO | | | | |
| | 2 Accident 3 Suicide 6 | Could not be | 26s. PLACE (| OF INJURY - Al ho | me, ferm, | street, fec | tory, offic | • | | 261. LOCATION (Street City or Town, State | | er or Rural | Route Number, |
| COMPLETED | 4 Homicide | determined | Junuity | , (-p-o | | | | | | Gray or lown, State | " | | |
| PLE | 29a. CERTIFIER (Check only | TIFYING PHY | SICIAN: To the post of | f my knowledge, de | ath occur | red at the t | ime, data | and place | , and due | to the cause(a) and m | enner as st | ated, | |
| WC | onel | | / \ | | | | | | | | | | s) and manner as stated, |
| | 296. SGNATURE AND TITLE | E OF CERTIFIE | EM | | | | | 29c. LIC | ENSE NU | MBER | 29d. DA | TE SIGNED | (Month, Day, Year) |
| BE | fuels. | A | | V V | BU | | | 1 | 53 | 550 | • | 6.1 | 23/64 |
| 2 | 30/NAME AND ADDRESS O | F PERSON W | HO COMPLETED CALL | ISE OF DEATH (ITE | M 27) (Type | s, Print) | | 1 | 1 | 1 | 1 | 1 | - |
| | Freder | ·v | 1th 10 | S IT | h | Su | 1 | 799 | 1 | Youll | e | XI | teg esten |
| | SEP 0 7 1 | 994 | 32. AEGISTA | AR'S SWATER | | | | | | | | | mal |
| | ULF VII | GO-T | | | | | | | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the four after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND | MENTAL | HYGIENE |
|--|--------|----------|
| CERTIFICATE OF DEATH | | REG. NO. |

| | 1 - STATE REGISTRAR | STATE OF MARYLA | ND / DEPAR | RTMENT OF H | HEALTH AND | | HYGIEN | E | | | |
|--------------------|---|--|------------------------------------|--------------------|-------------------------------|------------------|--|----------------|------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | CENTILIDATE OF BEATH | | | 2. DATE OF DEATH 3. TIME OF C | | | | 3. TIME OF DEATH | | |
| | Dorothy | Uplinge | er | | | August 20 | | | 94 | 3:15 A M | |
| | | | yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | | | PLACE (State or Foreign | |
| | 1 440-10-1304 | 1 M 2 X F 84 YRS. | | | | 9/30/1909 | | | Mar | yland | |
| œ | 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF | | | | | | | 7.0 | | | |
| 570 | Cherrywood Manor N | Jursing Cente | er | Keis: | terstown | | | Bal | timo | re | |
| DIRECTOR | 10a. STATE 10b. COUNTY | | | Y, TOWN OR LOCA | | | | | | tod. INSIDE CITY LIMITS? | |
| | Maryland Carro | 211 | Fi | <u>inksbur</u> | | | | - | | 1 X YES 2 NO | |
| RAI | Constitution and the contraction | 1 | | 10 | 21048 | | | | | HAT COUNTRY? | |
| FUNERAL | 3233 Murray Road | 12. WAS DECEDENT EVER IN I | II S ADMED | 1 12 148 05 | | **** 0210101 | - 14. M | | . A. | | |
| | 1 Never Married 2 Married | FORCES? 1 YES | 2 NO | If yes, sp | ENDENT OF HISPA | an, Puerto Ric | | or No- | Black, | — American Indian, White, atc. | |
| ВУ | 3 🔀 Widowed 4 🗌 Divorced | If I was the same and and | | 1 1 1 1 1 1 1 | 2 NO Speci | my: | | | Specify | White | |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade of | (TION ompleted) | (Give kind of w | USUAL OCCUPATION | ON ost of working | 16b. K | IND OF BUS | INESS/INDU | STRY | | |
| ZE | Elamentary/Secondary (0-12) Unknown | Cotlege (t-4 or 5+) | life. Do NOT us | se retired.) | | | 0.10 | II a m a | | | |
| OME | 17. FATHER'S NAME (First, Middle, Last) | | Home | maker | MOTHER'S N | ***** | | Home | ! | | |
| | Joseph Barncord | 4 | | | Emma | (Lee | | Sumame) | | | |
|) BE | 19a. INFORMANT'S NAME (Type/Print) | A | 19b. MAILING | ADDRESS (Street) | and Number or Rural | | | . State, Zlp C | ode) | | |
| 6 | Ronald L. Uplind | ier. Sr. | | | Rd., F | | | | | 1 /1 Q | |
| | 20a. METHOD OF DISPOSITION 1 🔀 Burial 2 🗆 Cremation 3 🗆 Remov | 20b. P | PLACEANDDATEC | OF DISPOSITION (NE | | DATE | | CATION — CH | | | |
| | 4 Donation 5 Donation Donation Donation | SI | tery, cremetory or of the LNSet. M | 1emoria | 1 Park | 8/23 | 194 (| Cumbe | rla | nd MD | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICES | NSEE | | 22. NAME AI | ND ADDRESS OF FA | ACILITY | | | | ie, P.A. | |
| | 5. Marje. | Sugar | | 202 | Greene | St | Cumb |) M | D 2 | 1502 | |
| | 23. PART I. Enter tha diseasas, or co- shock, or heart failura. Li | mplications that caused to at only one cause on aar | tha daath. Do n | not enter tha mo | de of dying, suc | ch ss csrdla | c or reapli | atory srres | it, | Approximate Interval Batween | |
| | IMMEDIATE CAUSE (Finsi disease or condition | | | | | | | | | Onset and Dasth | |
| | disease or condition a. Parareatic Clinican DUE TO (OR AS A CONSCOUENCE OF): | | | | | | | | | | |
| _ | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| 0 | Sequentially list conditions, If any, landing to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| CA | cause. Enter UNDERLYING CAUSE (Disease or Injury | csuse. Enter UNDERLYING | | | | | | | 1 | | |
| TE | that initiated events resulting in death) LAST | DUE TO (OR AS A C | ONSEQUENCE OF | 7): | | | | | | | |
| CERTIFICATION | d. | | | | | | | | | - | |
| | PART ii. Other algnificant conditions | contributing to deeth but | t not resulting i | in the underlyin | g ceuse given in | Part i. 24 | In. WAS AN | | | WERE AUTOPSY FINDINGS | |
| DIC. | | | | | | , | PERFORI | | | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| ME | | | | | | | | L | | OF DEATH? | |
| PHYSICIAN: MEDICAL | DID TOBACCO USE CONTRI | | | | UNCERTAI | N 🗆 | | | | | |
| S | | HOSPITAL: | 8. PLACE OF DEAT | OTHER: | | | | | | | |
| 1YS | t YES 2 NO 1 | 1 Inpatient 2 ER/Outpat | tiant 3 DOA | 4 3-Hursing Hom | e 5 🗆 Rasidenca | | Other (Specify) DESCRIBE HOW INJURY OCCURED | | | | |
| | 1 Netural 5 Pending | (Month, Day, Year) | | URY WO | URY AT PRK? YES 2 NO | 28d. DESCH | NBE HOW IN | JURY OCCU | RED | | |
| ВУ | 2 Accident Investigation 3 Suicide & Could not be | 28a. PLACE OF INJURY - | - At home, tarm, a | | | 281. LOCATI | ON (Street a | nd Number or | Rural Roo | ute Number. | |
| COMPLETED | 4 Homicide determined | Chu or Tourn Close) | | | | | | | , | | |
| 2LE | 29a. CERTIFIER (Check only t CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. | | | | | | | | | | |
| OMI | | On the basis of examination a | | | | | | | | and manner as stated. | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | n / 6 | - 40 | | 29c. LICENSE NUI | | . 1 | | | Month, Day, Year) | |
| O BE | Stephen) | Cagel F | ugel MD 128 | | | 8304 > 81 | | /20 | 0/94 | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEAT | 'H (ITEM 27) (Туре, | Print) | | | | | | 7.7 | |
| | Stephen Siegel. | | Main St | reet | Reiste | erstown | n, Md | . 21 | 136 | | |
| | 31. DATE FILED (Month, Day, Year) AUG 2 4 1994 | 32. REGISTRAR'S SIGNAT | TURE | | | | | | | | |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH IRENE MAE VALENTINE 1994 8:20 P Aug. 17 4. SOCIAL SECURITY NUMBER S. SEX BIRTHPLACE (State or Foreign 6. AGE (In vrs. last birthday IF UNDER 1 YEAR | IF UNDER 24 HRS 7. DATE OF BIRTH DAYS HOURS t M 2 FF 219-03-8088 77 Jan 13, 1917 PA 9a, FACILITY NAME (If not institution, give street and number 9b. CITY TOWN OR LOCATION OF DEATH C COUNTY OF DEATH DIRECTOR ALLEGANY Pages 1, 2, 3 SACRED HEART HOSPITAL CUMERLAND, MARYLAND RESIDENCE OF DECEDENT ton. STATE 10b. COUNTY toc. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND ALLEGANY t TYES 2 X NO Savage permit. FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? USA 13204 Barrellville Road use as the burial-transit 21545 the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Maxican, Puerto Rican, etc.)

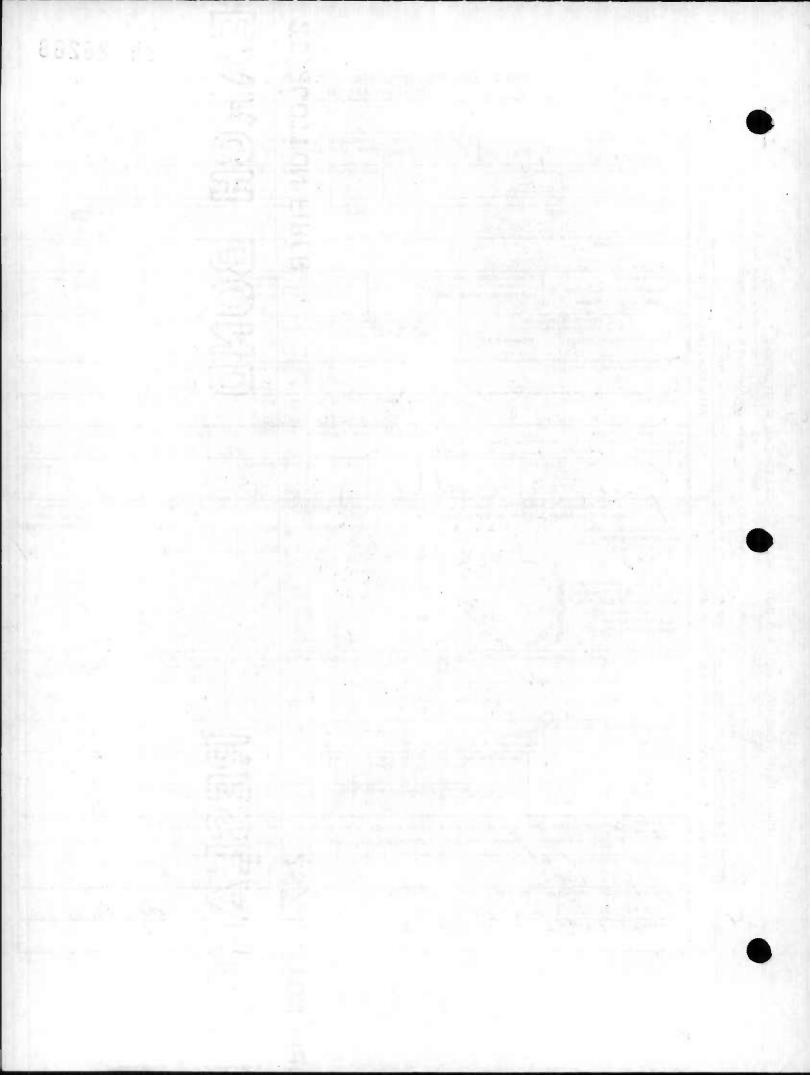
1 YES 2 X NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married BY 3 Widowed 4 Divorced white COMPLETED ts. DECEDENT'S EDUCATION 16a DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade ive kind of work done
Do NOT use retired.) should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) to ours after death. Page 6 may be retained by Florence M. (Baker) BE Russell E. Emerick notified 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 page 5 Savage, MD Mary E Valentine

**METHOD OF DISPOSITION

**ABurlet 2 © Cremetion 3 © Remove 21545 pe 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata must funeral director, 8/20 4 4 Donation 5 Other (Specify) Cumberland, MD Restlawn Memorial Park examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home una Cumberland, MD 21502 the 23. PART i. Enter the diseases, or complications that couldn't death. Do not enter the mode of dying, such as cardiac or respiratory arrest, medical lled in by Approximate shock, or heart failure. List only one cause on each line. Interval Batween Ö IMMEDIATE CAUSE (Final Onset and Death the cremation. disease Dr condition cute Myocardoa and completely to burial, crematic resulting in death) other traumatic event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING the death certificate be prior CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events the attending p resulting in death) LAST 0 PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 200 PERFORMED? any certificate has been signed the State Dept. of Health 1 TYES 2 THO Shows 1 YES 2 NO PHYSICIAN: HOSPITAL DR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL OTHER: t TYES 2 NO t ampatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 10 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED with marked, 1 Natural
2 Accident this 5 Pending Investigation 1 YES 2 NO DIRECTOR: After the hours after death tem 28 is mark BY 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 6 Could not be COMPLETED 4 Homicide 29s. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and ma TO THE HOSPITAL OF TO THE FUNERAL OF THE FUNERAL OF THE MITHIN 72 has IMPORTANT: If It (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 29b. SIGNATURE AND THE OF CHI 29c. LICENSE NUMBER 29d. DATE SIGNED/(Month, Day, Year) BE 351 3 2 HO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MENTO Selon VAH

31. DATE FILE NO. 25, 407 994

32. REGISTRATE SIGNATURE



| 1 | | | it permit | AND TO |
|---|--|---|---|--|
| | BALTIMORE, MARYLAND 21215-0020 | hours after death. Page 6 may be retained by the hospital or attending physician, s | y filled in by the funeral director, page 5 should be detached for use as the burial-transition, or removal. | the medical examiner must be notified at once. |
| | DIVISION OF VITAL RECORDS, P.O. BOX 68760. | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withher hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transf permit be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If tiem 28 is marked, or tiem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | . HYGIEN |
|---|----------|
| CERTIFICATE OF DEATH | REG. NO. |

| | 1 - STATE REGISTRAR | CEF | | ICATE | | | | MEN IAL | REG. NO. | Ė | | |
|--|--|--|---|--------------------|-----------------------------|------------|------------|--------------------|----------------------------------|------------------------------|------------------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) DOMINICK | J. VIE | LE | | | | | 2. DATE O | DA | - 1 | YEAR 3 | TIME OF DEATH PM |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 115-12-6406 1X | 6. AGE (In yrs. lest be 74 | irthday) YRS. | IF UNDER 1 | | HOURS | BARNI | | F BIRTH Day, Year) 5 19 | 20 | Country) | ACE (State or Foreign York |
| æ | 9a. FACILITY NAME (If not institution, give street and | | 9b. CITY, TOWN OR LOCATION OF DE Randallstown | | | | | | | | NTY OF DEA | |
| 6 | Northwest Hospita | 1 Center | | кат | ndal | lst | own | | | Ва | ltim | ore |
| DIRECTOR | MD 106. COUNTY Carroll | | 10c. CIT | Y, TOWN O | R LOCATIO S t m i | | er | | | | | Od. INSIDE CITY LIMITS? YES 2 NO |
| | 10e. STREET AND NUMBER | | | | | IP CODE | | | | t0g. CIT | | AT COUNTRY? |
| FUNERAL | 765 Velvet Run | | | | | 211 | | | | | | States |
| BY FU | 1 Never Married 2 W Married FOI | S DECEDENT EVER IN U.S. ARME RCES? 1 TYPY YES 2 NO YES, GIVE WITH OR DATES WWTT | | 11 | | Ify Cuben | , Maxican | n, Puerto Ri | (Specify Yes can, atc.) | or No- | 14. RACE — Bleck, \ Specify: | - American Indian, White, etc. White |
| 9 | 15. DECEDENT'S EDUCATION (Specify only highest grade complete | (Give | kind of v | USUAL OC | | | , | 16b. I | KIND OF BUS | INESS/INC | USTRY | |
| COMPLETED | Elementary/Secondary (0-12) Colleg | pe (1-4 or 5+) life. Do | NOT us | endei | - | | , | C | lubs | | | |
| BE CO | | Viele | | | | 18. MOTN | | | ddle, Maiden | Surname) | (un | known) |
| TO E | Barbara Viele | 19b. 8 | MAILING 65 | Velv | (Street and | Run | or Rural A | estm | inst | n, State, Zip er , | MD 2 | 1157 |
| | 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify) | | DDATE O | of DISPOSI | TION (Name | *** | 27/ | 94 ^{PATE} | | | City or Town | , State |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | Provi | <u> </u> | | | | | | Home | | | |
| | Katherine Prit | to - Switzer | | 41 | 12 W | ash | ing | ton | Rd . | Wes | tmin | ster. MD |
| | 23. PART I. Entar the diseasea, or compile shock, or heart failure. List online immediate CAUSE (Final disease or condition resulting in death) | DUE TO (OR AS A CONSCOU | NG | A | DE | No (| AR | | VOM | | | Approximate interval Between Onset and Daath |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | | |
| MEDICAL | PART II. Other significent conditions contr | | | | | cause gi | iven in I | | 24a. WAS AN PERFOR 1 YES 2 | MED? | A C | PERE AUTOPSY FINDINGS WAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? |
| AN | DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL | RIBUTE TO CAUSE | OF | DEATH | | | NO | ock only one | <u> </u> | | | |
| PHYSICIAN: | | PITAL: patient 2 - ER/Outpatient 3 - | DOA | OTHER | : | | | 6 Other | | | | |
| F | 27. MANNER OF DEATN 28 | Ba. DATE OF INJURY (Month, Day, Year) | Bb. TIM | E OF URY | 28c. INJUR WORK | (? | | 28d. DESC | RIBE NOW I | JURY OC | CURED | |
| В К | Accident Investigation | Sa. PLACE OF INJURY At home | , farm, a | M street, facto | 1 YE | S 2 [| NO | 26f. LOCAT | TION (Street a | nd Number | or Rural Rou | ite Number, |
| TED | 4 Homicide detarmined | building, atc. (Specify) | | | | | | City or | Town, State) | | | |
| 29a. CERTIFIER (Check only one) 29a. CERTIFIER (Check only one) 29a. CERTIFIER (Check only one) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 3 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. | | | | | | | | | nd manner as stated. | | | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | air les | | | 2 | P9c. LICEI | NSE NUM | 7 3 | 3] | 29d. DAT | E SIONED (N | Ionth, Day, Mear) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPI | LETED CAUSE OF DEATH (ITEM 2 | 27) (Type, | Print) | AC | TO. | M | 0 | 2/11: | 13 | 1 | |
| | 31. DATE FILED (Month, Dey, Year) AUG 2 6 1994 | BEGISTRAR'S SIGNATURE | | | | | | | | | | |

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | | 1. DECEDENT'S NAME (First, | Middle, Last) | | | | | | | | | 2. DATE OF | DEATH | | | 3. TIME OF OEATH |
|---|---------|---|-------------------|---|-------------|--|----------------|-------------------------------------|-----------------|------------|-----------|--------------------------|-------------|---------------------|-------------|---|
| | | LESTER VAN | CE WAR | NICK JR. | | | | | | | | Augus | t 18 | 1994 | YEAR | 2:00 p m |
| | | 4. SOCIAL SECURITY NUMBER | ER | 5. SEX | 6. AGE (/ | In yrs. lest bir | | UNDER 1 YE | AR | IF UNDER 2 | 24 HRS. | 7. DATE OF | BURTH | | 6. BIRTHE | PLACE (State or Foreign |
| - | 1 1 | 217-05-021 | 2 | 1 M 2 F | | 75 | YRS. MON | FTHS DA | W8 1 | HOURS | MIN. | (Month, D | 27] | 1918 | Md | |
| should | | 9e. FACILITY NAME (If not in | stitution, give s | treet and number) | | | 9b. | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | | | 9c. COUNTY OF DEATH | | |
| 2,3 | СТОВ | Garrett Me | morial | Hospita | 1 | | Oakland, | | | | | | Garrett | | | |
| - - | [[| RESIDENCE OF DEC | 10b. COUNTY | , | | 1 10 | Oc. CITY, TO | WH OP I | OCATIO | 200 | | | | | | 10d. INSIDE CITY |
| Page | DIRE | Md | Garr | ot+ | | | Oakland | | | | | | | LIMITS? | | |
| ermit | | 10e. STREET AND NUMBER | Gali | ect | | | Uakia | ilid | 10f. 2 | ZIP CODE | | | - | 10a CITI | | 1 YES 2 X NO |
| UZO physician. burial-transit permit. Pages | FUNERAL | Rt. 7 Bo | v 1435 | | | | | | | | | | US | TAT COOKING | | |
| uician. al-trar | 5 | 11. MARITAL STATUS | | 12. WAS DECEDEN | | | 0 | 13. WAS | | | | IC ORIGIN? (| Specify Yee | | | — American Indian. |
| UOZOO | BY F | 1 Never Married 2XX | | FORCES? 1 | 2 NO | 2 NO It yes, specify Cuben, Mexican, Pur | | | | | in, etc.) | | | White otc. | | |
| of the state of | | 3 Widowed 4 Divo | | <u>WW 2</u> | | | <u> </u> | | | | | | | | WIITLE | |
| | ETED | (Specify only | EDENT'S EDU | | | (Give k | dind of work | done durin | | | 7 | 16b. KI | ND OF BUS | SINESS/IND | USTRY | |
| oital or | | Elementary/Secondary (0 Unknown | -12) | College (1-4 or 5 | +) | | NOT use ret | , | | | | | | | | |
| he hospit detached once. | COMPL | 17. FATHER'S NAME (First, M. | iddle Lest) | | | ır | uck I | rive | _ | 10 MOTH | EDIO MAI | WE (First, Mide | ransı | | tion | |
| # 6 4 E | | Lester V | | ick Sr | | | | | | | | Belle | | , | | |
| retained to should be should notified | BE | 19a, INFORMANT'S NAME (7) | | iten bi. | | 19b. M | AILING ADD | ORESS (St | pet and | | | Dette | | | Code1 | |
| 2 - 12 | 임 | Mary Jan | e Warn | ick | | | | | | | | and, | | | , | |
| may be | H | 20a, METHOD OF DISPOSITI | ON | | 20b. | PLACEAND | DATEOFDE | SPOSITIO | N (Name | ne of | | DATE | 1 | | City or Tow | rn, State |
| . Page 6 ma ral director, p | | 4 Donation 5 Other | (Specify) | ovel from State | ceme | etery, cremate P | hilos | Cen | ete | ery | 8-2 | 1-94 | WEs | tern | port. | Md. |
| eath, Page 6 m funeral director, xaminer must | | 21. SIGNATURE OF FUNERA | 1 | 22. NAME AND ADDRESS OF FACILITY Boal Funeral Service | | | | | | | | | | | | |
| · | | 111 Church St. Westernport, Md. | | | | | | | | | | | | | | |
| urs after of in by the removal. | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate | | | | | | | | | | | | | | |
| Do i po | | shock, or he IMMEDIATE CAUSE (Fin | ert fellure. | Liet only one ceu | use on ea | nch line. | | | | | | | | | | Interval Between Onset and Death |
| within within cremation, rent, the | | disease or condition resulting in death) o. Myochaclast Isy a ct is a Due to (or as a consequence of): | | | | | | | | | | | | | | |
| rted within completely fal, cremati event, t | | rosulting in coultry | | DUE TO | (OR AS A | CONSEQUE | NCE OF): | 1 | | | | | | | | |
| executed and common bundle, common matic ev | N N | Sequentielly list conditi | 000 | ъ | | | | | | | | | | | | |
| o cia pe | CATION | if any, leading to immed cause. Enter UNDERLYI | diate | DUE TO | (OR AS A | CONSEQUE | NCE OF): | | | | | | | | | |
| D by Deby | 윤 | CAUSE (Disease or inju | | cDUE TO | (OR AS A | CONSEQUE | NCE OF: | | | | | | | | | |
| eath certification attending mtal Hygiel | RTIF | resulting in death) LAS | г | | | | | | | | | | | | | į |
| the death y the atten d Mental injury, o | 뮝 | DART II ON THE STATE OF | | | | | | | | | | | | | | |
| - 56 - | DICAL | PART II. Other eignifice | nt condition | e contributing to | deeth be | ut not reeu | ilting in th | ne under | lying (| ceuse gl | iven in i | Part i. 24 | a. WAS AN | | | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| 5 E E E | ă | | | | | _ | | | | | | 1 | YES 2 | HO | | COMPLETION OF CAUSE OF DEATH? |
| law requires as been sign bept, of Heat | ME | | | | | | | | | | | _ | | | | 1 _ YES 2 _ NO |
| | AN: | 05 WAS SASS DEFENDED TO | | | | | | | | | | | | | | |
| ate ate | SICI | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOSPITAL: | 7 - 1 | ALTIVI | | HER: | | | | ck only one) | | | | |
| SICIAN: The certificate the State in the State | >- | 1 YES 2 NO | | 1 Inpatient 2 | | | Bb. TIME OF | | Home . INJUF | | idence | 6 Other (S 28d, DESCR | | u il inv oo | CIBED | |
| PH start PH | / PH | 1; Netural 5 | Pending | (Month, E | | | INJURY | | WORK | | NO | 200. DESCR | IBE HOW II | NONT OC | CONED | |
| After death | D BY | a D autota | Could not be | 28a. PLACE C | F INJURY | — A1 home, | 1erm, street | 1, fectory, | office | | | 281. LOCATIO | | ind Number | or Rural Ro | oute Number, |
| 2 aff ag 2 | ETEC | | determined | bullaing, | etc. (Speci | ny) | | | | | | City or 1 | own, State) | | | |
| OB DIRE | MPLE | 29e. CERTIFIER (Check only | IFYING PHYSI | CIAN: To the best of | my knowle | edge, death | occurred at | the time. | date er | nd place. | and due | to the cause | e) and man | ner se stat | ed | |
| HOSPITAL FUNERAL within 72 TANT: If | WC | | | | | | | | | | | | | | | end manner ee stated. |
| | ЕСО | 29b. SIGNATURE AND TITLE | OF CERTIFIER | 1 0 | |) | | | T: | 29c. LICEN | NSE NUM | BER | | 29d. DAT | E SIGNED (| Month, Day, Year) |
| TO THE TO THE De filed Y | 00 | Polen | 18/0 | lams | M | 1 | | | | 773 | 981 | // | | • | D | 2294 |
| | 5 | 30. NAME AND ADDRESS OF | PERSON WH | O COMPLETED CAU | SE OF DEA | ATH (ITEM 27 | 7) (Type, Prin | 0 5 | 51 | RY | 1 1 | DAN | 5. | MID | / | |
| 5 | | 311 N | orth | 4 | 47 | 54. | | D | KI | an | 7 | mo | 1. | 315 | 220 | |
| | | AUG 2 3 19 | OA de | JA STANEGISTRA | H-SPIGN | turk. | | | | | -41 | | | - | | |
| | | WAG C A 12 | JT /" | | | | | | | | | | | | | |

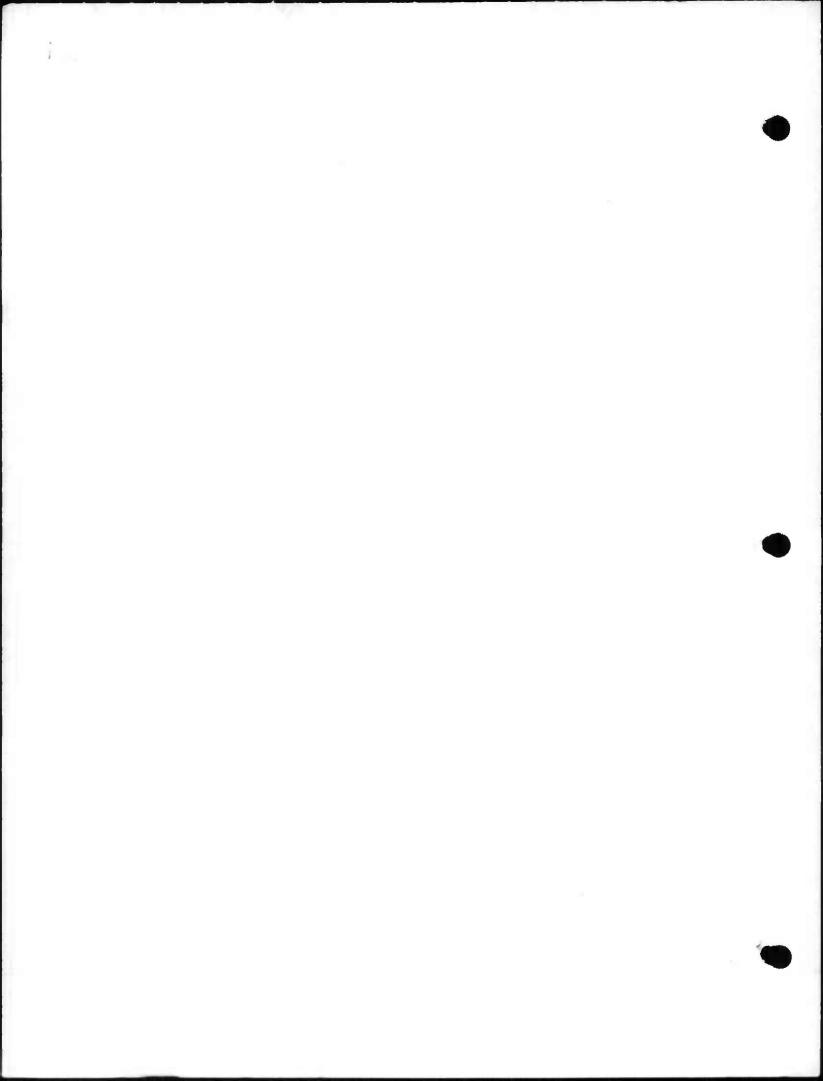
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DIVISION OF VITAL RECORDS, P.C

| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Sours after death. Page 6 may be retained by the hospital or arranding nextransfer of the law requires that the death certificate be executed within Sours after death. Page 6 may be retained by the hospital or arranding nextransfer. | DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|--|--|
| TO THE HOSPITAL DR ATTENDING PH | TO THE FUNERAL DIRECTOR: After this obe filed within 72 hours after death with | IMPORTANT: If Item 28 is marked |

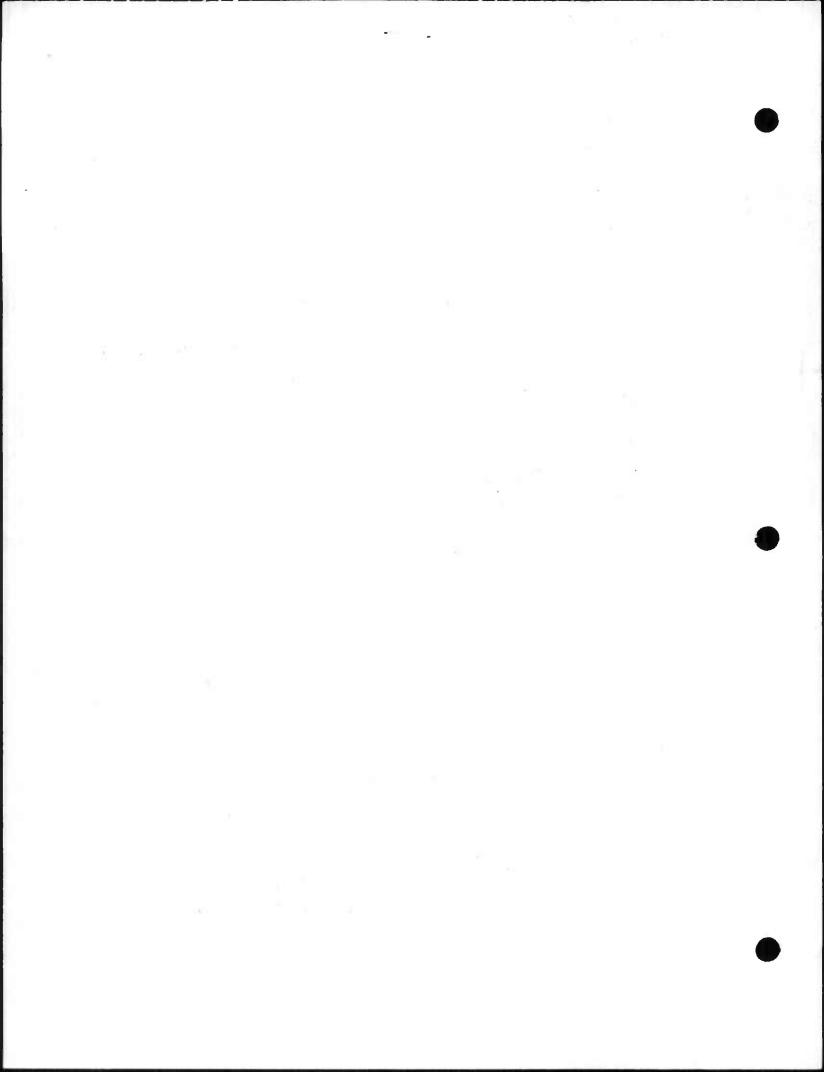
| | 1 - FOR STATE REGISTRAR | STATE OF MARY | AND / DEPARTM | | | MENTAL HYGIEN | E | | | |
|--|---|--|---|---------------------|--|---|------------------------------|--|--|--|
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) WENDEL | R | | | JEATH. | 2. DATE OF DEATH AUGUST 17 | 1994 | 3. TIME OF DEATH | | |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. lest birthdev) | raman r make | | | | 2330 M | | |
| | 222-24-5897 | ™XM2□F 55 | YRS. MO | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | | 939 DAG | THPLACE (State or Foreign http:/ SBORO, DELAWARI | | |
| TOR | 9a. FACILITY NAME (If not institution, give st. 7213 ZION CHURCH RESIDENCE OF DECEDENT | | 98 | SALISE | R LOCATION OF D URY | EATH | 9c. COUNTY OF DEATH WICOMICO | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY MARYLAND WICO | | | OWN OR LOCAT | ION | | 10 | | | |
| | 10e. STREET AND NUMBER | MICO | SALIS | | ZIP CODE | | 44 - 0/7/7/7/4 | 1 TYES 2 NO | | |
| FUNERAL | 7213 ZION CHURCH | | | 21801 | | WHAT COUNTRY? | | | | |
| BY | 11. MARITAL STATUS t Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 TYES IF YES, GIVE WAR OR D | 2 NO | cify Cuban, Maxico | T OF HISPANIC ORIGIN? (Specify Yes or No—ben, Maxican, Puerto Rican, etc.) O Specify: Specify: WHIT | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | |
| MP | 12 4 HOUSING SPECIALIST POULTRY | | | | | | | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Maiden | Surname) | | | |
| BE | FRED N. WEST | | | | HELEN (| | | | | |
| 9 | | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION 1 | oval from State | D. PLACE AND DATE OF D petery, cremetory or pre- GEORGE | ISPOSITION (Ne | ne of | OATE 200. LOCATION — City or Town, State AUG 21,1994 CLARKSVILLE, DELAWARE | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | | OLORGE E | | D ADDRESS OF FA | CILITY | | | | |
| | · Add St | Medan) | | | | MELSON STREET, FRA | | L SERVICES | | |
| | 23. PART I. Enfar the disease of conshock, or heart februa. L. IMMEDIATE CAUSE (Finel disease or condition resulting in death) | . My us | ach lina. | | le of dying, aud | | ratory arrest, | Approximate Interval Between Onset and Death | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | |
| | d | | | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other algorificent conditions | a contributing to death i | out not resulting In the | ha underlying | cause given in | Part I. 24a. WAS AN PERFORI | MEO? | b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| ¥ | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PL | ACE OF DEATH (Ch | eck only one) | | | | |
| Sic | EXAMINER? | HOSPITAL: 1 Inpetient 2 ER/Out | | THER: Nursing Home | 1.4 | 8 Other (Specify) | | | | |
| | 27. MANNER OF DEATH 1. Netural 5 Pending | 26s. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF | F 28c. INJU WOI | IRY AT | 28d. DEŞCRIBE HOW IN | JURY OCCURED | | | |
| 2 Accident 28a PLACE OF IN HIRV. At home tree state of th | | | | | | | | | | |
| 3 Suicide 6 Could not be detarmined building, stc. (Specify) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as state. | | | | | | | | | | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. NCENSE NUI | | | D (Month, Day, Year) | | |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO | (TRASSO | 145 E | | RROLLS | T+ SALIS | SBURY | mo | | |
| | AUG 1 9 1994 | 32. BEGISTRAR'S SIGN | OF Randall | | | | | | | |



31. DATE FILED (Month, Day, AUG 2 6

12, REGISTRAR'S SIGNATURE
Film Davidson Rondall

| _ | | FOR 1 - STATE REGISTRAR | STATE OF I | MARYL | | | TMENT ICATE | | | | MENTAL | HYGIEN REG. NO. | E | | |
|-----------------------|--------|--|---|------------------------|-----------------|--------------------------|---|--|---------------------|-----------------|------------------------------|----------------------|-------------|---------------|---|
| | , | 1. DECEDENT'S NAME (First, Middle, Last) ROBERT | Н | • | W | ILS | ON | | | | 2. DATE O | | "2 <u>9</u> | 9 4 AR | 3. TIME OF DEATH |
| | | 4. SOCIAL SECURITY NUMBER 225-54-7080 | 5. SEX t XX 2 F | 1.00 | (In yrs. lest | birthday) YRS. | MONTHS | DAYS | IF UNDER | 24 HRS. MIN. | 7. DATE OF | 697. Year) 0 / 42 | | .Count | HPLACE (State or Foreign ry) RGINIA |
| 5 | בטו | 90. FACILITY NAME (If not institution, give st ROUTE #135 RESIDENCE OF DECEDENT | treet and number) | | | | 96. CITY, TOWN OR LOCATION OF DEATH BLOOMINGTON | | | | | | NTY OF D | | |
| | DIREC | 10a. STATE 10b. COUNTY PENNA YOR | | | | | ELT | | TION | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X 100 |
| A CENTER | EHAL | RR 3, BOX | 197 | | | | 10f. ZIP CODE 17314 | | | | | US | | WHAT COUNTRY? | |
| 2 | - | 11. MARITAL STATUS 1 Never Married 2 M Married 3 Widowed 4 Divorced 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 M XES 2 NO IF YES, GIVE WAR OR DATES V I E T N A M | | | | | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or N If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 X X Specify: | | | | | or No- | 14. RACI | E — American Indian, k, Whita, atc. |
| Once. | ורבובט | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | | +) | (Giv life. I | e kind of w Do NOT us | USUAL OC vork done do e retired.) | uring mo | ON est of workin | g | | ANSP | | | N |
| TI I | u | 17. FATHER'S NAME (First, MIDDIN, Last) ROBERT EARL W | ILSON | | | | | | | | ME (First, Mic | A . Z | Sumame) | RMA | N |
| e notified | | JOANN WILSON | | | 19b. R F | MAILING | BO) | (Street a | 97, | Or Aural A | TA, P | A. 1 | 7 3 1 (| Code) | |
| r must b | | 20s. METHOD, OF DISPOSITION Burlal 20 Cremetion 3 Removal from State Donellon 5 Other (Specify) 20c. DOATION - City or Town, State Company (Company Compa | | | | | | | | | | | | | |
| i examiner must | | Elden H Tu | llelf | | | | HAF | RKI | ns F | .н. | Inc. | | | | 17314 |
| event, the medical | | 23. PART I. Enter the diseasea, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arreat, shock, or heart failure. List pnly one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due to (or as a conscouence of): | | | | | | | | | | | | | |
| | | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO | (OR AS A | CONSEQU | JENCE OF | j: | | | | | | | | |
| Y, or other traumatic | | CAUSE (Disease or Injury that Initiated events resulting in death) LAST | DUE TO | (OR AS A | CONSEOU | JENCE OF | 7: | | | | | | | | |
| rs any inju | 1000 | PART II. Other significant conditions | | | | · . | n the unc | ieriying | | | _ | 4a. WAS AN PERFOR | MED? | 24b | WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| DHVSICIAN M | | DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXYES 2 \(\triangle \triangle 00 NO | HOSPITAL: | | 28. PLACE | OF DEAT | S N H (Check of OTHER | nly one) | UNC | ERTAIN | | | 27.011 | | |
| marked, or RV DHVS | | 27. MANNER OF DEATH 1 Natural 5 Pending | 1 Inpatient 2 28s. DATE OF (Month, D | INJURY | | 28b. TIME | E OF | 28c. INJI WO | RK? | | | Specify) RO | | CURED | Treident. |
| Z8 IS | | 2 Accident Investigation 3 Suicida 8 Could not be 4 Homicide datarmined | 28a. PLACE C building, | F INJURY etc. (Spec | cify) | | vus | | | | 28f. LOCAT City or Rou | Town, State) | nd Number | | Route Number, |
| COMPLETED | | 29a. CERTIFIER (Check only one) 1 | | | | | | | | | | | | | s) and manner as stated. |
| 2 H | | 296. SIGNATURE AND TITLE OF CERTIFIER | Gh | Z | | | | | | NSE NUM | | | | | (Month, Day, Year) |
| 1 | | - 0 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | |



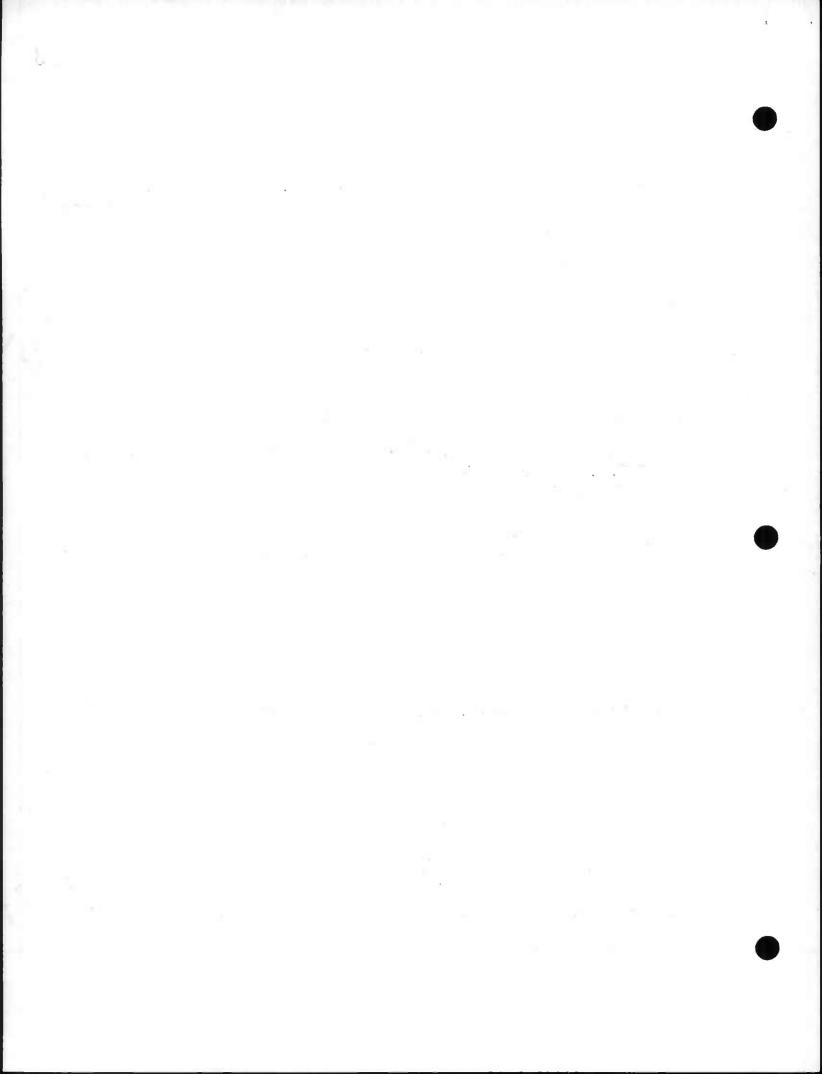
| | . 2. 3 should | | |
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| | L soes 1 | | |
| Z | Milit sum |) | |
| physical | building: | | ed . |
| mbriefing | use as the | | 3262 |
| hospital o | tached for | | ce. |
| ned by the | ould be der | | led at on |
| ay be retai | page 5 sh | | be notif |
| Page 6 m | al director, | | ner mus |
| nours after death. Page 6 may be retained by the hospital | y the funer | removal. | саі ехаш |
| Thours | filled in b | tion, or rer | the medi |
| uted with | tificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use at the | rial, cremati | or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| ite be execi | ysiclan and | prior to bu | traumati |
| uth certifica | tending phy | ate Dept. of Health and Mental Hygiene prior to | or other |
| hat the dea | d by the at | and Menti | ny Injury. |
| requires t | been signer | of Health | shows a |
| N: The law | ficate has I | State Dept | Item 23 |
| PHYSICIA | Ce | h with the | arked, or |
| ATTENDING | CTDR: Afte | after deat | 28 Is m |
| PITAL OR | ERAL DIRE | in 72 hours | T: If Item |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed wi | TO THE FUNERAL DIRECTOR: After this | be filed within 72 hours after death with the | IMPORTANT: If Item 28 Is marked, |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

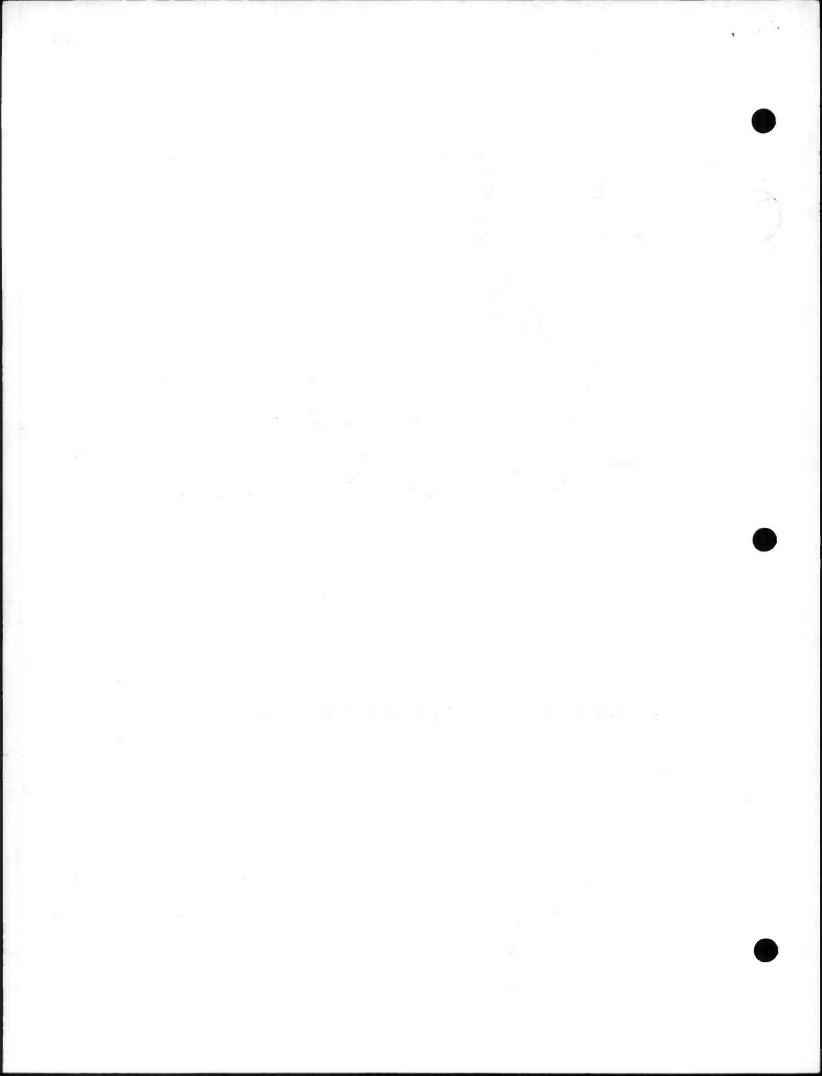
1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| _ | REGISTRAN | | | | COLIE | ICAL | - OF | DEA | П | | REG. NO. | | | | |
|---|---|-------------------------|---------------------------|-------------------------------------|-----------------|--------------|----------------------|------------|-----------------|-----------------------|-------------------------------|------------------|--------------------|---|--|
| | 1. DECEDENT'S NAME (First, | | | | | | | | | 2. DATE O | F DEATH DA | ٧ | YEAR | 3. TIME OF OEATH | |
| | Hilda Pauline | | | | | | | | | August | 10, | 1994 | | 6:38 P M | |
| | 4. SOCIAL SECURITY NUMB | ER | 5. SEX | 6. AGE (In yrs. lesi | | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. MIN. | 7. DATE Of | F BIRTH Day, Year) | | 8. BIRTH Countr | PLACE (State or Foreign | |
| | 263-16-8489 | | 1 🗆 M 2 🔜 F | 75 | YRS. | | October 25,1918 Geor | | | | | gia | | | |
| ~ | 9a. FACILITY NAME (if not institution, give street and number) | | | | | 9b. CITY | TOWN C | R LOCATIO | ON OF DE | EATH | | 9c. COU | COUNTY OF DEATH | | |
| 0 | St. Mary's Nursing Center | | | | | Le | onar | dtow | /n | | | St. Mary's | | | |
| DIRECTOR | 10a. STATE | 10b. COUNTY | | | 10c. CIT | Y, TOWN C | R LOCAT | ION | | | | tod. INSIDE CITY | | | |
| 2 | Marvland | Calv | ert | | Hur | ting | tow | 1 | | | | | - 1 | LIMITS? | |
| | 10e. STREET AND NUMBER | OULV | CIC | | I HUI | CLIIE | | . ZIP CODI | E | | | 10g. CIT | IZEN OF V | VHAT COUNTRY? | |
| FUNERAL | 341 Sun Par | k Lane | | | | | 1 2 | 20639 |) | | | Uni | tod | States | |
| 5 | 11. MARITAL STATUS | | 12. WAS DECEDEN | IT EVER IN U.S. ARI | | 13. | MAS DEC | ENDENT C | F HISPAN | VIC ORIGIN? | (Specify Yas | | | E — American Indian, c, Whita, atc. | |
| BY | 1 Never Married 2 3 Widowed 4 Divo | | IF YES, GIVE | | | | | 2 NO | | in, Puerto Ric y: | sen, etc.) | | Speci | | |
| | | | | | | | | | te | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | | | | | | | | | | | | |
| COMPLETED | Elementary/Secondary (0 | -12) | College (1-4 or 5 | +) | | aker | | | | | | | | | |
| MO | 17. FATHER'S NAME (First, MI | iddle, Last) | | | - CALCA | unci | | 18 MOTE | HER'S NA | ME (First, Mic | idle Meiden | Surnamal | | | |
| | George Marv | in Rou | ntree | | | | | | | Chamb | | Surramer | | | |
| BE | t9a. INFORMANT'S NAME (7) | | ner cc | 190 | . MAILING | ADDRESS | (Street a | | | Route Number | | . Stere, Zic | Code) | | |
| 2 | Linda Frye | Durst | | 1 | | | | | | | | | | 20639 | |
| | 20a. METHOD OF DISPOSITI | ON | | 20b. PLACEA | NDDATE | OF DISPOS | | | | DATE | _ | | City or To | | |
| | 4 ☐ Donation S ☐ Other | (Бресіўу) | | Svlvan | Abb | ev M | emor | ial | Park | | Clea | r Wa | ter. | Florida | |
| | 21. SIGNATURE DE EMBRAI | L SERVICE/CIC | english . | 1 1 | | 22. | NAME AN | D ADDRES | SS OF FA | CILITY | | | | | |
| - 1 | ▶ FULL | | nsfield | JI. Me | 0052 | | | | | neral | | N | (| and 20650 | |
| \neg | 23. PART I. Enter the di | seeses, or c | omplications the | t caused the dea | ath. Do r | | tha mo | de of dyi | ng, suci | h ss cardia | c or reapli | ratory sr | rest. | Approximats | |
| | 23. PART I. Enter the diseases, or complications that caused the death, Do not enter tha mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final | | | | | | | | | | | | | | |
| | disease or condition | → | (a | 10-1 | n | 101 | 1 | 11 | - | | | | | 11/ | |
| | resulting in death) | | DIVE TO | (OR AS A CONSEC | UENCE O | P): | 40 | 1 | 1/ | 7 | | | | 71 | |
| z | | | a | Uni | ma | , | M | 10 | Sto | m | / | | | 0 | |
| CERTIFICATION | Sequantisity list conditi If any, leading to immed | diata | DUE TO | (OR AS A CONSEC | UENCE O | -): | 1 | | | | | | | | |
| S | cause. Entar UNDERLYi CAUSE (Disesse or inju | | | | | _ | 1 | | | | | | | | |
| | that initiated events resulting in dasth) LAS | т . | DUE TO | (OR AS A CONSEC | UENCE OF | F): | 1 | | | | | | | | |
| Ü | | | l | | | | | | | | | | | | |
| | PART ii. Other significa | nt conditions | contributing to | death but not re | esuiting | in the un | dariying | cause (| lven in | Part i. 2 | 4a. WAS AN | | 24b. | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO | |
| EDICAL | | | | | | | | | | _ | YES 2 | | | COMPLETION OF CAUSE OF DEATH? | |
| ME | | | | | | | | | | | | | | 1 TES 2 NO | |
| | DID TOBACCO | USE C | ONTRIBUTE | TO CAUS | E OF | DEAT | H Y | ES 🗌 | NO | | | | | NA | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOSPITAL: | | | OTHER | | ACE OF D | EATH (Ch | eck only one) | | | | | |
| YSI | 1 TES 2 NO | | 1 Inpatiant 2 | ER/Outpatient 3 | | 4 Nun | | • 5 □ Ra | eldenca | 6 Other (| Specify) | | | | |
| | 27. MANNER OF DEATH Netural 5 | Pending | 28a. DATE OF (Month, E | | 26b. TIM INJ | E OF URY | | RK? | | 28d. DESCI | RIBE HOW IN | JURY OC | CURED | | |
| B | 2 Accident | nvestigation | 00. 81.405.6 | | | М | | ES 2 | NO | | | | | | |
| | | Could not be detarmined | building, | F INJURY — At hor atc. (Specify) | ne, farm, i | rtreet, fact | ory, offici | • | - 1 | 281. LOCAT City or | ION (Street a Town, State) | nd Number | or Rural R | loute Number, | |
| | | | | | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMPLER: On the least of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and manner as stated. | | | | | | | | | | | | | | | |
| 8 | | | Con the basis of | xamination and/gr is | nveatigatio | n, In my o | pinion, d | eath occur | ed at the | time, data as | nd piaca, and | dua to th | na Cause(s |) and manner as stated, | |
| B | 296. SIGNATURE AND TITLE | PICENTIFIEN | d | Alala | _ | - 11 | 1) | 29c. LICE | ENSE NUN | MBER | | 29d. DAT | E SIGNED | (Month, Day, Year) | |
| <u>و</u> ا | | | | | | | | | | | | | | | |
| | / / | The strain on the | 11 | | | 2007270 | 1 | | | | | _ | | 0150 | |
| H | J. Patrick / | | , M. D. | Medica | 1 Ar | ts. | RTq8 | 5., L | eona | rdtow | n, Ma | ryla | nd 2 | 0650 | |
| | AUG 12 | | Jalia 100 | AR'S SIGNATURE | fally | | | | | | | | | | |
| | 1198 7 | | 0 | | | | | | | | | | | DHMH 16 Pay 1/80 | |



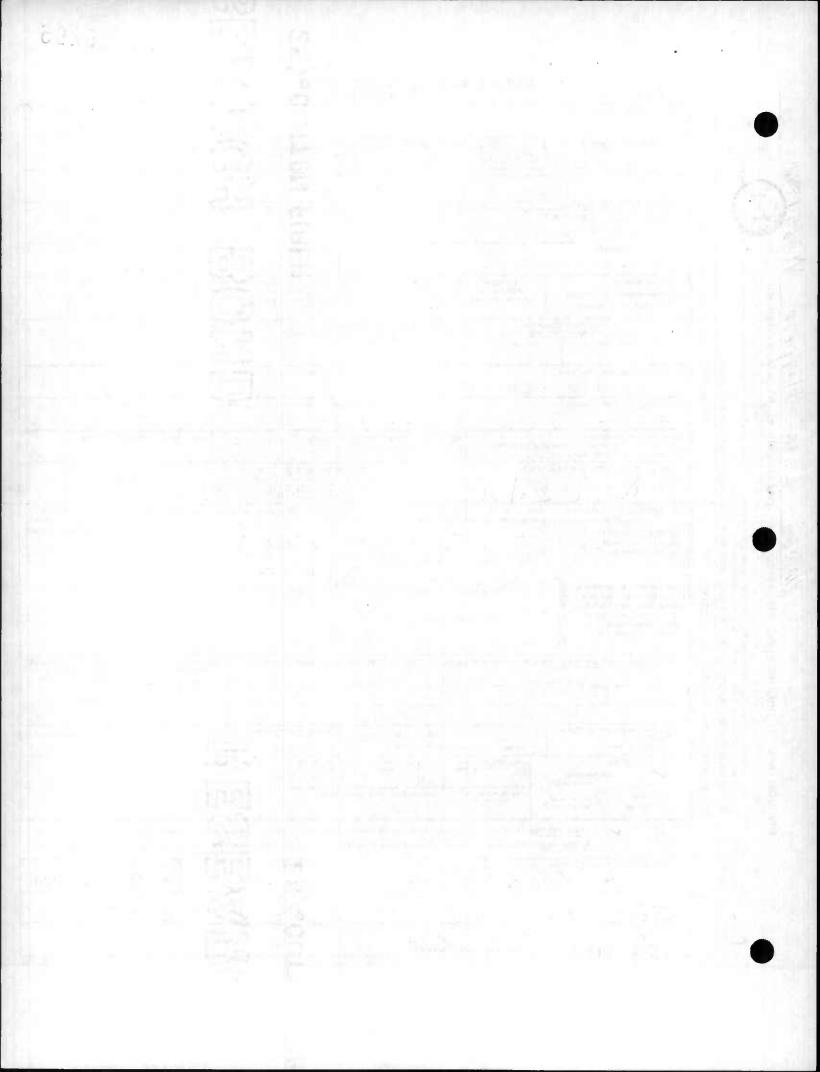
| - | an | . 20 | |
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| | F | W 4 | ark |
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| | R: / | hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| | E | aff | 28 |
| | IRE | DUIS | Ema |
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| | 1 - FOR STATE REGISTRAR | TATE OF MARYLAND / | | OF HEALTH AND | MENTAL HYGIEN | Ē | |
|--------------|---|--|-------------------------------------|-------------------------------|---|--------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | O. DEATH | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| 1 3 | Melvin Lerov White | | | | August 18, | | 1:10 P. M |
| | 4. SOCIAL SECURITY NUMBER 5. S | SEX 6. AGE (In yrs. last | birthday) IF UNDER | 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BIRT | HPLACE (State or Foreign |
| - 5 | 212-26-0758 | X M 2 □ F 66 | YRS. MONTHS | DAYS HOURS MIN. | (Month, Day, Year) December 1,19 | Coun 127 Ra1+ | imore |
| | 9a. FACILITY NAME (If not institution, give street a | | 9b. CITY, | TOWN OR LOCATION OF D | | 9c. COUNTY OF | |
| DIRECTOR | St. Mary's Nursing (| Center | Leon | nardtown | | St. Mar | |
| E C | 10a. STATE 10b. COUNTY | | 10c. CITY, TOWN O | R LOCATION | | | 10d, INSIDE CITY |
| | | Mary's | Leonard | | | | 1 YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER 29 A Kline Drive | | | 101. ZIP CODE 20650 | | United | WHAT COUNTRY? |
| N | 11. MARITAL STATUS 12. | WAS DECEDENT EVER IN U.S. ARK | MED 13. V | MAS DECENDENT OF HISPA | NIC ORIGIN? (Specify Yea | or No.— 14. RAC | E — American Indian. |
| | | FORCES? 1 YES 2 NI IF YES, GIVE WAR OR DATES | 0 1 | YES 2 X ND Specific | in, Puerto Rican, etc.) | Blac | ck, White, etc. |
| ВУ | 3 Widowed 4 Divorced | | | - LEG I ZEND OPOCH | ,. | | ite |
| | 15. DECEDENT'S EDUCATIO (Specify only highest grade comp | | CEDENT'S USUAL OC | CCUPATION | 16b. KIND OF BUS | INESS/INDUSTRY | |
| | | | Do NOT use retired.) | wing most or working | | | |
| <u>A</u> | 12 | Ban | k Officia | al | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | 18. MOTHER'S NA | ME (First, Middle, Maiden | Surname) | |
| ш | Owen Wilson White | | | Mary El | izabeth Ad | ams | |
| 0 B | 19a. INFORMANT'S NAME (Type/Print) | 19b | . MAILING ADDRESS | (Street and Number or Rural | Route Number, City or Town | , State, Zip Code) | |
| F | Owen Wilson White | 31 | 3 South | Stricker St | eet, Balti | more,MD | 21223 |
| | 20a. METHOD OF DISPOSITION 1 X Burlai 2 Cremation 3 Removal f | | NO DATE OF DISPOSI | TION (Name of | DATE 20c. LOC | CATION — City or T | own, State |
| | 4 Donation 5 Other (Specify) | /) Charle | matory or other place) es Memori | al Gardens | 8/21 Leon | nardtown | , Maryland |
| 1 1 | 21. SIGNATURE - THE BAL SERVICE LICENSE | Km/h | | NAME AND ADDRESS OF FA | | | |
| | Edward N. Brins | field, or MO | 0050 | insfield Fu | | | |
| \vdash | 23. PART I. Enter the diseases, or comp | | | O. Box 279 | Leonardto | wn Mary | Approximate |
| | shock, or heert fellure. List of | only one cause on each line. | | | | | interval Between |
| | IMMEDIATE CAUSE (Finel disease or condition resulting in dasth) | Refrac | most | Congesti | rie Hear | A fail | une Chast and Daeth |
| | | DUE TO (OR AS A CONSEO | DUENCE OF): | 114 | | , | |
| NO | Sequentielly liet conditions, b | DUE TO (OR AS A CONSEO | Jalgn | ngitalion | • | | |
| ERTIFICATION | if any, leeding to immediate cause. Enter UNDERLYING | OUL TO (ON AS A CONSEC | OENCE OF): | U | | | |
| 유 | CAUSE (Diseese or Injury that Initiated events | DUE TO (OR AS A CONSEO | UENCE OF: | | | | |
| Ē | resulting in deeth) LAST | | 0.7. | | | | j |
| E E | d | | | | | | + |
| ابا | PART II. Other significent conditions co | | eulting in the un | derlying cause given in | Part I. 24s. WAS AN | | . WERE AUTOPSY FINDINGS |
| EDICA | Chronic Obst | ructine in | ng dis | Pose- | 1 TYES 2 | . / | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEC | | | (| | - ' | ^ | 1 TES 2 NO |
| | DID TOBACCO USE CON | ATRIBUTE TO CAUS | E OF DEATI | H YES NO | | | |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | 28. PLACE DE DEATH (CH | eck only one) | | |
| Si | | OSPITAL: Inpetient 2 - ER/Outpetient 3 | DOA 45 Nurs | l: ling Home 5 🗌 Raaldenca | 6 Other (Specify) | | |
| PHY | 27. MANNER OF DEATH | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW IP | JURY OCCURED | |
| > | 1 Natural 5 Pending 2 Accident Investigation | (monn, Day, roar) | M | 1 YES 2 NO | | | |
| ED B | 3 Suicide 8 Could not be | 28s. PLACE OF INJURY — A1 horn building, etc. (Specify) | ne, tarm, street, facto | ory, office | 281, LOCATION (Street a City or Town, State) | nd Number or Rural | Routs Number, |
| | 4 Homicide datarmined | | | | Oily Or Jown, State) | | |
| COMPLET | 29e. CERTIFIER (Check only | : To the best of my knowledge, dea | ith occurred at the 16 | me, date and place, and due | to the cause(a) and man | ner as stated. | |
| W | anal | the basis of axamination and/or in | | | | | a) and manner as stated. |
| | 296. SIGNATURE MAD TITLE OF CERTIFIER | | | 294 LICENSE NUI | - | | |
| 8 | Julian sa | many | | | eri | | 0 (Month, Day, Year) |
| 임 | 30. NAME AND ADDRESS OF PERSON WITO CO | MPLETED CAUSE OF DEATH (ITEM | 27) (Type, Print) | D27189 | | | 11/ |
| | | | | Toomande | m M1 | 4 20650 | |
| | Zahir Yousaf, M.D. 31. DATE FILED (Month, Day, Year) | 32 REGISTRAD'S SIGNATURE | | ,Leonardtow | n, marylan | <u>u</u> 20030 | |
| | AUG 1 9 1994 | Jalin Davidson Rand | lall | | | | |



| me: LolA Neipeir Warezen | DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020 | with suits after death. Page 6 may be retained by the hospital or attending physician. | the completely filled in by the funeral director, page 5 should be detached for use as the burial-training permit and the contraction or removal. | vent, the medical examiner must be notified at once. | |
|--------------------------|---|---|--|--|--|
| MA | DIVISION OF VITAL RECORDS, P.O. BOX 6876 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deam permitten be accorded with a first death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the amending physician and compressly filed in by the funeral director, page 5 should be detached for use as the burial-training be filed within 72 hours after death with the State Dept, of Health and Mental Hypern pater to burial common or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |

| FOR 1 - STATE REGISTRAR | STATE OF MARY | | MENT OF HEA | | ENTAL HYGIENE REG. NO. | | | | |
|--|--|--|--|---|--|----------------------------|--|--|--|
| DECEDENT'S NAME (First, Middle, L SOCIAL SECURITY NUMBER | Lola N. | Woodrow | | 1 | 2. DATE OF DEATH 8- | 26 44 | 9:45 H | | |
| 215-28-0315 se. FACILITY NAME (If not institution, g | 1 🗆 M 2 💢 F | 78 YRS. M | | DURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Larch 1, 1 | Cour | aryland | | |
| | l of Cecil Cou | | Elkton | Scanion or Sex | | Cecil | | | |
| | ecil | 1,000 | rth East | 3 | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | |
| 35 Dr. Carr Ro | | | 2 | 21901 | T's | U.S.A | WHAT COUNTRY? | | |
| 10. STREET AND NUMBER 35 Dr. Carr Ro 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YES | 2 X NO | 13. WAS DECENE If yes, specify 1 — YES 2 | Cuban, Mexican, | ORIGIN? (Specify Yea Puerto Rican, etc.) | Bla | No— 14. RACE — American Indian, Black, Whita, atc. Specify: White | | |
| 15. DECEDENT'S (Specify only highest of Elementary/Secondary (0-12) 8 17. FATHER'S NAME (First, Middle, Last | | 16a. DECEDENT'S US (Give kind of wo. life. Do NOT use Homema) | rk done during most of retired.) | working | 16b. KIND OF BUS | INESS/INOUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Lust George | W. Woodrow, S | | | . MOTHER'S NAMI | E (First, Middle, Maiden S Minnie Ti | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Marion M. Wood | irow | | Box 25 - | | MD 21916 | State, Zip Code) 6-0025 | | | |
| 21. SIGNATURE OF FUNERAL SERVICE 23. PART I. Enter the diseases, ahock, or heart felix limited by the disease or condition resulting in death) | or complications that cause one. List only one cause on | ed the death. Do no | HICKS 103 W E1kto | Home I lest Sto on MD of dying, auch | or Funeral ckton Stre 21921-5521 as cardiac or reapir | ls, P.A. | Approximate interval Between Onset and Death | | |
| Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS | A CONSEQUENCE OF): A CONSEQUENCE OF): | | | | | | | |
| PART II. Other algnificant cond | itions contributing to death | but not resulting in | the underlying co | ouse given in P | PERFORM 1 YES 2 | MED? | Ib. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | HOSPITAL: | | OTHER: | OF DEATH (Chec | | | | | |
| | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME | RY WORK? | AT : | Other (Specify) 28d. DESCRIBE HOW IN | JURY OCCUREO | | | |
| 3 Suicide 8 Could not 4 Homicide determine | be 28e. PLACE OF INJUR | TY — At home, farm, streedly) | reet, factory, office | 1 | 261. LOCATION (Street ar City or Town, State) | nd Number or Rura | I Route Number, | | |
| e (II | HYSICIAN: To the best of my kno MINER: On the basis of examinat | | | | | | o(a) and manner as stated. | | |
| 29b. SIGNATURE AND TITLE OF CERT | Man | 1), | 7 | c. LICENSE NUMB | 7/6 | 29d, DATE SIGNE | 26 94 | | |
| 30. NAME AND ADDRESS OF PERSON 31. DATE PILED (Month, Day, Year) SED 07 1004 | A. 32. REGISTRAR'S SIG |) // | 1 W- 1 | High | 5+ | EIK | Tow Md. | | |



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事 burial, cremation,

other traumatic event,

0 injury,

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DIRECTOR: After this certificate hours after death with the State

CERTIFICATION

PHYSICIAN: MEDICAL

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completely filled in by the rial, cremation, or removal.

and

Hygiene prior to the attending physician

0

STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) GERALD 4. SOCIAL SECURITY NUMBER

ITEMS: 23 PART I, 27, PER MEO FILM G-715 9/26/94 t.t STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

6. AGE (In yrs. last birthday)

YRS.

22

CERTIFICATE OF DEATH REG. NO 2. DATE OF DEATN 3. TIME OF DEATH AUG 28 1994 WARD 6:30P DATE OF b... (Month, Day, Year 2, IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTN 8. BIRTNPLACE (State or Foreign HOURS Dec. Maryland

9b. CITY, TOWN OR LOCATION OF DEATH DERWOOD

10f, ZIP CODE

9c. COUNTY OF DEATN MONTGOMERY

RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION Montgomery Derwood

5. SEX

1X M 2 - F

10d. INSIDE CITY 1 YES 2- NO 10g. CITIZEN OF WHAT COUNTRY?

19813 Muncaster Road

(Specify only high

20855 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No—II yes, specify Cuben, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify:

United States

11. MARITAL STATUS Never Merried 2 Merried 3 Widowed 4 Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES

18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY

18. MOTNER'S NAME (First, Middle, Maiden Surneme)

DATE

9/1

14. RACE — American Indian. Black, White, etc. Specify: White

Elementery/Secondary (0-12) College (1-4 or 5+) 12

15. DECEDENT'S EDUCATION

Construction

Utility

17. FATHER'S NAME (First, Middle, Last) George Earl Ward

Marion Elaine Nichols 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code)

19a. INFORMANT'S NAME (Type/Print) George E. Ward

Same as #10e.

20c. LOCATION — City or Town, State Alexandria, Virginia

20e. METHOD OF DISPOSITION
1 ☐ Buriel 2 Å Cremetion 3 ☐ Removal from State 4 Donellon 5 Other (Specify)

21. SIGNATURE OF FUNERAL SERVICE LICENSEE

MI

20b. PLACE AND DATE OF DISPOSITION (Name of Metropolitan Crematory

22. NAME AND ADDRESS OF FACILITY Muriel H. Barber Funeral Home 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, | Approx

shock, or heart fellure. List only one ceusa on each line IMMEDIATE CAUSE (Final disesse or condition resulting in death)

CARDIAC ARRHYTHMIA

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert i.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury thet initieted events resulting in death) LAST

> 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO

24h. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

Approximate

Interval Between

Onset and Death

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL

26. PLACE OF DEATH (Check only one) HOSPITAL: Inpatient 2 - ER/Outpatient 3 - DOA

4 Nursing Nome Residence 6 Other (Specify)

1 NES 2 NO 27 MANNER OF DEATH 1 XX Natural

28e. DATE OF INJURY (Month, Day, Yeer) 26e. PLACE OF INJURY — At home, ferm, streel, lactory, office building, etc. (Specify)

28c. INJURY AT 1 YES 2 NO

28d. DESCRIBE NOW INJURY OCCURED 281. LOCATION (Street end Number or Rural Route Number, City or Town, State)

29e. CERTIFIER

2 Accident

3 Sulcide

4 Nomicide

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the lime, date end place, end due to the ceuse(e) end menner ee stated.

2 💢 MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(e) end menner ee stated.

296. SIGNATURE AND TITLE OF CERTIFIER Cluste 100

6 Could not be

29c. LICENSE NUMBER O.C.M.E. 29d. DATE SIGNED (Month, Day, ▶ AUGUST 29 1994

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201.

32. RESISTAR DEGNATURE

death. Page 6 may be retained by the hospital or attending physician. Inneral director, page 5 should be detached for use as the burial-transit BALTIMORE, MARYLAND 21215-0020

requires that the death certificate be executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760 HOSPITAL OR ATTENDING PHYSICIAN: The law TO THE HOSPITAL (TO THE FUNERAL DE FILED WITHIN 72 HORIZANT: If IN

BALTIMORE, MARYLAND 21215-0020.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCICAE

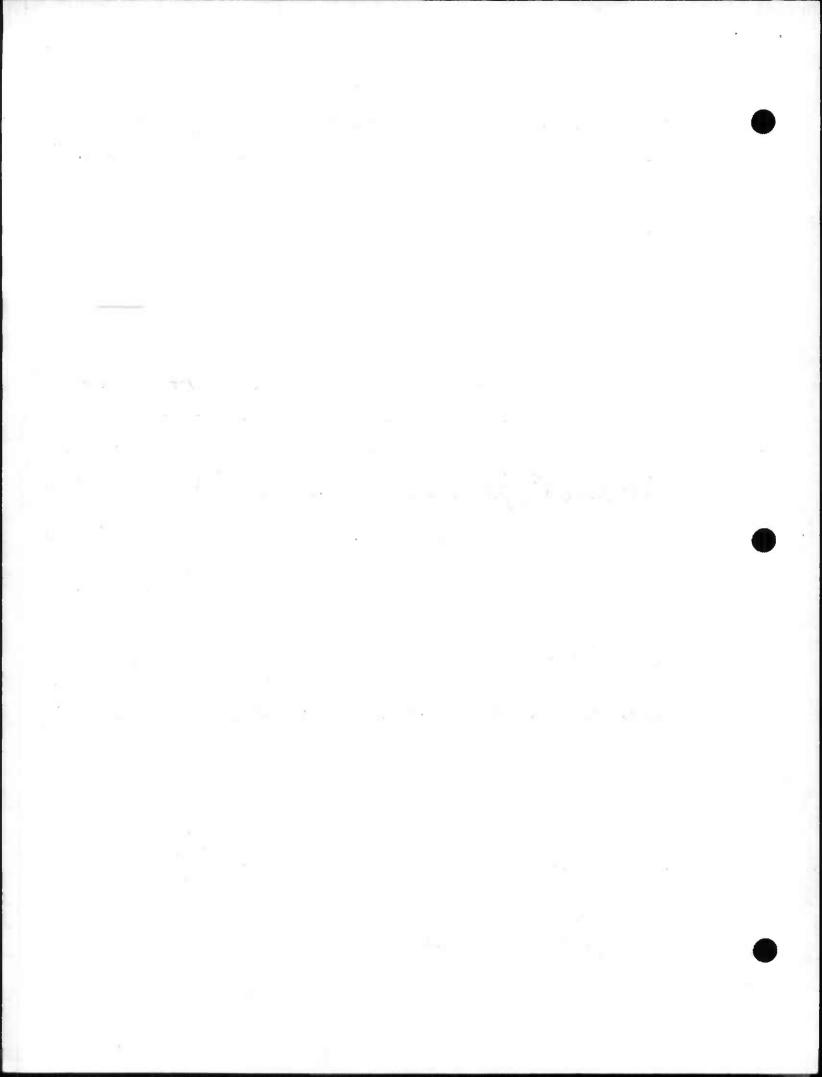
| | 1 - STATE REGISTRAR | | | | ICATE OF | DEATH | MENTAL | REG. NO | _ | | |
|--------------|--|----------------------------------|----------------|------------------|------------------------|--|---------------------|------------------------------|---------------|-------------------------|--------------------------------|
| - 1 | t. DECEDENT'S NAME (First, Middle, Las | (1) | | | | | 2. DATE (| OF DEATN | AY | YEAR 3. | TIME OF DEATN |
| | JOHN M. WOO 4. SOCIAL SECURITY NUMBER | | ACE //- | form bright do a | | | AUGI | | 9,19 | | 2:00 I |
| | 216-68-7956 | t M 2 D F | . AGE (In yrs. | YRS. | MONTHS DAYS | HOURS MIN. | (Month, | Day, Year) | | Country) | CE (State or Foreign |
| | 9a. FACILITY NAME (If not institution, giv | | | THS. | at OUTY TOUG | | | 7 30, | 1956 | Mary | |
| н | | | .005. | | Annapo | OR LOCATION OF D | EATN | | 9c. COUNT | TY OF DEATI | N |
| CTOR | ANNE ARUNDEL | GENERAL H | OSPI | TAL | Airiape | 7113 | | | ANN | E ARI | JNDEL |
| DIREC | 10e. STATE 10b. COUR | | | | Y, TOWN OR LOCA | | | | | too | I. INSIDE CITY |
| | Maryland Anne | Arundel | | Ca | pe St.CI | air,Anna | polis | \$ | | 10 | LIMITS? X NO |
| ËRAL | 100. STREET AND NUMBER 896 Chestnut Tr | oo Dr | | | to | H. ZIP CODE | | | | | COUNTRY? |
| N N | | | | | | 21404 | | | 0.3 | S.A. | |
| FUN | tt. MARITAL STATUS t Never Merried 2 Married | 12. WAS OECEDENT E FORCES? t | YES 2 | XNO XNO | | CENDENT OF NISPA pecify Cuben, Mexico | | | e or No- 1 | 4. RACE — Black, WI | American Indian, hite, etc. |
| ВУ | 3 Widowed 4 X Divorced | IF YES, GIVE WAR | OR DATES | | | S 2 NO Specif | | , | | | White |
| | ts. DECEDENT'S EI | | 16a. | DECEDENT'S | USUAL OCCUPATI | ION | 166 | KIND OF BU | SINESS/INDU | | |
| H | (Specify only highest gra Elementary/Secondary (0-12) | College (t-4 or 5+) | | | work done during m | | 100. | KIND OF BO | 314233/1400 | 31111 | |
| P | 12 | Conege ((~ Of 5 +) | Br | ick La | ayer | | | Const | ructio | on | |
| COMPLETED | t7. FATNER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S NA | AME (First, M | liddle, Malden | Surneme) | | |
| ш | James LeRoy Wood | ruff | | | | Joan V. | Clar | k | | | |
| 0 B | 19a, INFORMANT'S NAME (Type/Print) | | | | | and Number or Rural | | | | | |
| 5 | Joan V. Woodruff | | | 896 CI | nestnut | Tree Dr. | Cape | St.C | lair, | Md.2 | 1404 |
| | 20e, METHOD OF DISPOSITION t Burlel 2 Cremetion 3 Re | moral from State | 20b.PLAC | E AND DATE | OF DISPOSITION (N | ame of | DATE | | CATION — CI | | |
| | 4 Donetion 5 Other (Specify) | THOUSE HOLD STATE | - Hin | Teres | ter Ceme te | ery | 8-2 | 3 Ann | apolis | s, Md. | |
| | 21. SIGNATURE DE FUNERAL GENYTES | LICENSEE | | | 22. NAME A | ND ADDRESS OF FA | CILITY JO | hn M. | Taylo | or Fur | neral |
| | 21. SIDNETURE OF FUNERAL CERTIFICATION OF FACILITY John M. Taylor Funeral 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home Inc. 147 Duke of Gloucester St. Annapol | | | | | | | | | | |
| ERTIFICATION | reaulting in death) a. NARCOTIC, PHENCYCLIDINE AND ETHANOL INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease or Injury that Initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| S | | , d | | | | | | | | | |
| AL. | PART ii. Other significant conditi | ons contributing to de | ath but no | t reauiting | in the underlying | ng cause givan in | Part i. | 24s. WAS AN PERFOR | | | RE AUTOPSY FINDI |
| MEDICAL | | | | | | | | t X YES 2 | | COL | MPLETION OF CAUS |
| ME | | | | | | | | | | 1 [| YES 2 NO |
| ä | DID TOBACCO USE CON | TRIBUTE TO CAUS | SE OF DE | ATH YE | S NO [| UNCERTAI | N 🗆 | | | | |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PL | ACE OF DEAT | OTHER: | | | | | | |
| YSI | t X YES 2 □ NO | 1 Inpetiant 2 XE | | | 4 - Nursing Nor | ne 5 🗆 Raaldenca | a 🗆 Other | (Specify) | | | |
| РНҮ | 27. MANNER OF DEATN 1 Natural 5 Pending | 28e. DATE OF IN. (Month, Day, | | 28b. TIM INJ | URY W | JURY AT ORK? | 2ad. DEŞC | CRIBE NOW I | NJURY OCCU | RED | |
| B | 2 Accident Investigation | | | 9:04 | 1 | YES 2 NO | UNKNO | | | | |
| 8 | 3 Suicida a Could not b | building, atc | Specify) | home, tarm, s | street, factory, offic | ce . | 28f. LOCA City o | TION (Street of Town, State) | 896 CH | r Aural Aoute ESTNUT | TREE DR. |
| ᄪ | 29e. CERTIFIER | | | HOME | | | ANNAP(| OLIS, M | 1D. | | |
| OMPL | (Check only | YSICIAN: To the best of my | | | | | | | | | |
| Ö | | NER: On the basis of axam | nination and/o | or investigation | n, in my opinion, | death occured at the | time, date e | end placa, er | nd due to the | cause(e) end | menner as atate |
| BE (| 29b. SIGNATURE AND TITLE OF CERTIF | IER | | | | 29c. LICENSE NUI | MBER | | 29d. DATE | SIGNED (Mo | nth, Day, Yeer) |
| 10 | Muly Fol | Unight MD | | | | O.C.M. | E | | AUGU | ST 2 | 0_1994 |
| | | RIGHT MD | 111 | Pen | n Stree | et, Bal | | re, N | | - | |
| | 31. DATE FILED (Month, Day, 16ar) AUG 25 19 | 32. REGISTRAR'S | SIGNATURE | 0 . | | | | | | | |
| | MUG 23 19 | 34 Julia di | walen | Rardall | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with pours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit pennit. The being within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be mutified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

| | FOR STATE REGISTRAR | STATE OF MA | RYLAND / DEPA CERTI | RTMENT OF H | EALTH AND DEATH | MENTAL HYGIEN | E | | | |
|---------------|--|---------------------------------|-----------------------------------|--|-------------------|---|--------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last | • | | | | 2. DATE OF DEATH MONTH DA | Y YEAR | 3. TIME OF OEATH | | |
| | AUDREY WILKINS | 1 10 | drey Winfi | ~ | | JULY 23 | 1994 | 9:23 P M | | |
| 4 | 4. SOCIAL SECURITY NUMBER | 5, SEX 6. | AGE (In yrs. last birthday | MONTHS DAYS | HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | Coun | | | |
| | 579-42-2175 1 M 2 KF 67 YRS. Jun 11, 1927 England 9e. FACILITY NAME (# not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9e. COUNTY OF DEATH | | | | | | | | | |
| <u>۳</u> | THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY | | | | | | | | | |
| ٤ | RESIDENCE OF DECEDENT 10e. STATE 10b. COUN | | | | | | | | | |
| DIRECTOR | | Mary's | | rry, town on Loca Cotland | rion | | | 10d. INSIDE CITY LIMITS? | | |
| | 10M STREET AND NUMBER | TALY D | | | f. ZIP CODE | | 10g. CITIZEN OF | 1 ☐ YES 2 ☒ NO WHAT COUNTRY? | | |
| FUNERAL | Bayfront Drive | | | | 20687 | | U.S.A | | | |
| ₹ | 11. MARITAL STATUS | 12. WAS DECEDENT E FORCES? 1 | | | | NIC ORIGIN? (Specify Yes | | CE - American Indian, ck, White, etc. | | |
| BY | 1 Never Merried 2 Merried 3 Widowed 4 Divorced | IF YES, GIVE WAR | | | 2 XNO Speci | | C | | | |
| | 15. DECEDENT'S ED | UCATION | | 'S USUAL OCCUPATION | | 16b. KIND OF BUS | | • 23.0 | | |
| H. | (Specify only highest grade Elementery/Secondary (0-12) | College (1-4 or 5 +) | life. Do NOT | f work done during mo use re tired.) | ost of working | | | | | |
| COMPLET | 12th Grade | | Hon | nemaker | | Home | | | | |
| - | 17. FATHER'S NAME (First, Middle, Last) Samuel. | Cockings | | | 18. MOTHER'S NA | ame (First, Middle, Meiden ence Ma: | - | Carnes | | |
| BE | 190. INFORMANT'S NAME (Type/Print) | COCKINGS | | IG ADDRESS (Street) | 1 | Route Number, City or Town | | ar nes | | |
| 2 | John Phillip Wil | kinson | | | | land, Mary | | 687 | | |
| | 20e. METHOD OF DISPOSITION 1 X Burlet 2 Cremetion 3 Re | moval from State | 20b. PLACE AND DAT | | | | CATION — City or T | | | |
| | 4 Donetion 5 Other (Specify) | revers 1 | Charles' | | | 1 1 | eonardto | | | |
| | 61.00 | 126 | 1. | Matti | ngley-Ga | rdiner Fun | eral Hom | e, P.A. | | |
| _ | Typichaeka | Sparce | liner | | | Leonardto | | land 20650 | | |
| | 23. PART Enter the diseases, or ahock, or heart failure | List only one cause | on asch lins. | not entar tha mo | eds of dying, suc | ch as cardisc or respi | ratory srreat, | Approximate interval Between | | |
| | IMMEDIATE CAUSE (Final disease or condition | Hust | i Mydou | 1 heur | Min | | | Months | | |
| | resulting in death) | DUE TO (OF | AS A CONSEQUENCE | | 0.400 | | | 0,00000 | | |
| Z | Sequentially list conditions, | b | U | | | | | | | |
| AŢĬ | if sny, issding to immedista cause. Enter UNDERLYING | DUE TO (OF | AS A CONSEQUENCE | OF): | | | | | | |
| 띮 | CAUSE (Disesse or injury that initiated events | C. DUE TO (OF | AS A CONSEQUENCE | OF): | | | | | | |
| CERTIFICATION | reaulting in dasth) LAST | d | | | | | | | | |
| AL C | PART II. Other significant condition | ons contributing to de | sth but not resulting | In the undsriving | g cause givan in | Part I. 24a, WAS AN | AUTOPSY 24 | b. WERE AUTOPSY FINDINGS | | |
| S | | | | | | PERFOR | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| MEDIC | | | | | | | | 1 YES 2 NO | | |
| | DID TOBACCO USE | CONTRIBUTE | TO CAUSE O | | YES N | _ [2] | | | | |
| PHYSICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | OTHER: | LACE OF DEATH (C) | | | | | |
| H | 27. MANNER OF DEATH | 28a. DATE OF IN. | | ME OF 28c. INJ | URY AT | 6 Other (Specify) 26d. DESCRIBE HOW II | JURY OCCURED | | | |
| ВУ Р | 1 Natural 5 Pending 2 Aceldent Investigation | (Month, Day, | Year) II | | PRK? YES 2 NO | | | | | |
| ED B | 3 Suicide 6 Could not be | 28a, PLACE OF II | JURY — At home, farm (Specify) | , street, factory, offic | • | 281. LOCATION (Street a City or Town, State) | nd Number or Rural | Route Number, | | |
| 1 | 4 Homicide determined | | | | | | | | | |
| COMPLET | | SICIAN: To the bast of my | | | | | | | | |
| ខ្ល | 1 | IER: On the basis of exam | ination end/or investiga | ion, in my opinion, d | | | | | | |
| 96 | HUMM CONT | en. | | | 29c. LICENSE NUI | MBER | 29d. DATE IGNE | D (Nonth, Day, Year) | | |
| 2 | 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CAUSE | OF DEATH (ITEM 27) (Ty) | | 1 | | Rab | 14 | | |
| | Stormus O' Kiny | 1)0NV | 5 Hopkins | losjitu | b00 | N Work St | MALIN | Who. | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S | SIGNATURE | | | 0 | | | | |
| | LUDE OF THE | The attentities | provocave | | | | | | | |



| | FOR 1 - STATE REGISTRAR | STATE OF N | MARYLAND / DE | | ENT OF I | | | | YGIENE EG. NO. | | | | |
|---------------|---|-------------------------|---|---|-------------------------|----------------|-----------------------|----------------------------|-------------------|-----------------------------|--------------|--|----|
| | 1. DECEDENT'S NAME (First, Middle, Las | () | - OLIT | 111107 | TIL OI | DLA | | 2. DATE OF I | DEATH | | _ | 3. TIME OF DEATH | _ |
| 1 1 | LEO MODESTUS WED | ΓΙ.ΔΝΤ | | | | | | JULY : | 2 2 1 | 994 | YEAR | 2035 | м |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. lest birti | hday) IF U | MOER 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF E | HRTH | . 774 | 8. BIRTI | IPLACE (State or Foreign | |
| | 578-20-7127 | 1 √2 M 2 □ F | 79 Y | YRS. MONTHS DAYS HOURS MIN. | | | (Month, De DECEMBE | | 1014 | Count | NSYLVANTA | | |
| | 9e. FACILITY NAME (If not institution, give | street end number) | .,, | 9b. CITY, TOWN OR LOCATION O | | | ON OF O | | 1 9, 1 | | NTY OF C | | |
| 8 | ST. MARY'S HOSPIT | TAI. | | Т | EONAR | חדרונו | VI. | ST. MARY'S | | | | ADVIO | |
| 5 | RESIDENCE OF DECEDENT | | | | | | , N | I SI. MARY | | | | ARYS | _ |
| DIRECTOR | 10a. STATE 10b. COUN | | 10 | 10c. CITY, TOWN OR LOCATION | | | | | | 10d. INSIDE CITY LIMITS? | | | |
| | MARYLAND ST. | MARY'S | | LEXIN | GTON | | | | | | | 1 TYES 2 NO | |
| RA | | | | | 10 | f. ZIP COD | E | | | 10g. CITI | ZEN OF | WHAT COUNTRY? | |
| FUNERAL | RT 1, BOX 118A | I do whe propositi | T EVER IN U.S. ARMED | | | 0653 | 2 1024 | | | | | STATES | |
| | 1 Never Merried 2 Nerried | FORCES? 1 | YES 2 NO | | If yea, ap | ecify Cube | n, Mexica | NIC ORIGIN? (S | | or No- | | E — American Indian, k, White, etc. | |
| B | 3 Widowed 4 Divorced | IF YES, OIVE W | AR OR DATES | | 1 🗌 YES | 2 X NO | Specif | y: | | | Spec WH 1 | | |
| 8 | 15. DECEDENT'S ED (Specify only highest gra | DUCATION | | | AL OCCUPATI | | | 16b. KIN | D OF BUSI | INESS/IND | | | _ |
| lij. | Elementary/Secondary (0-12) | College (1-4 or 5 a | life Do I | NOT use retir | tone during mo red.) | ost of working | ng | | | | | | |
| I P | 12 | | PLU | MBER | | | | Di | EFENS | SE | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOT | HER'S NA | ME (First, Middl | e, Melden S | Surneme) | | | |
| BE | PETER LAURENCE | | | | | MAI | RY L | OUISE 1 | BANNO | N | | | |
| 0 | 19e. INFORMANT'S NAME (Type/Print) | | 19b. MA | AILING ADD | RESS (Street | and Number | or Rural | Route Number, C | City or Town, | State, Zip | Code) | | |
| - | MARY H. WEILAND | | RT | 1, B | OX 11 | 8A, I | EXI | NGTON | PARK. | MAR | YLAI | ND 20653 | |
| | 20e. METHOO OF DISPOSITION 1) Buriel 2 Cremetion 3 Re | moval from State | 20b. PLACE AND to cemetery, cremeto. | ry or other pl | lace! | | | DATE | 20c. LOC | ATION | City or To | own, State | |
| | 4 Denetion 5 Other (Specify) | Continues: | IMMACUL | ATE H | | | | | LEXI | NGTO | N P | ARK, MARYL | AN |
| | BRINSFIELD FUNERAL HOME | | | | | | | | | | | | |
| - 1 | MICHAEL K. E | | | | P.O. | BOX | 279 | . LEONA | ARDTO | WN. | MARY | YLAND 2065 | 0 |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between | | | | | | | | | | | | |
| | IMMEDIATE CAUSE /Final Ones and Death | | | | | | | | | | | | |
| | disease or condition | | | | | | | | | | | | |
| | | T DUE TO | OR AS A CONSEQUEN | ICE OF): | 0 | 40 | 2 | ON | 111 | 20 | 15 | 110 | |
| No. | Sequentially list conditions, | DUE TO | | EMIC CARDIO | | | | 10 MY OPATHY | | | MY | | |
| CERTIFICATION | if sny, leading to immediate cause. Enter UNDERLYING | RE | ERAC | TO | Ry | 0 | DA | JGE | CT | 111 | 15 | 1 | |
| 필 | CAUSE (Disesse or Injury that Initiated events | OUE TO | OR AS A CONSEQUEN | ICE OF): | 7 | 0 | 1 | | 0 | , 0 | 0 | | |
| E | resulting in desth) LAST | a H | EHIS | <t< td=""><td>+</td><td>11</td><td>4</td><td>181</td><td>E,</td><td></td><td></td><td></td><td></td></t<> | + | 11 | 4 | 181 | E, | | | | |
| Ö | DADT II. Other elgoliticant can dist | | death to a second | 101 | • | | | - | | | - | | |
| 18 | PART II. Other significant condition | 1 C 11 L | death but not resul | LA S | R 14 | g ceuse | given in | Part I. 246 | PERFORM | | 246 | . WERE AUTOPSY FINDING AWAILABLE PRIOR TO | |
| ED | VENIK | + CAL | TR | TICK | K 17 | 411 | 11/ | 1 | YES 2 | NO | | OF DEATH? | |
| 2 | DEP.P | hev. | 0 1/0 | 01 | . 11 | | 1 | 24 | n-s | 57 | | 1 YES 2 NO | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | 1 | 1 07 | 70 | 11/2 | ACE OF D | EATH (Ch | eck only one) | 176 | الد | | | _ |
| SCI | EXAMINER? | HOSPITAL: | ER/Outpatient 3 🗆 🛭 | | HER: | | | | | | | | |
| ¥ | 27. MANNER OF DEATH | 28a. DATE OF | INJURY 26 | b. TIME OF | - | JURY AT | reidence | 6 Other (Sp 28d, DESCRI | | JURY OC | CURED | | _ |
| | 1 Natural 5 Pending | (Month, D | lay, Year) | INJURY | | YES 2 | NO . | | | | | | |
| Э ВУ | 2 Accident Investigation 3 Suicide 6 Could not b | 28e. PLACE O | F INJURY At home, to | ferm, street, | , factory, offic | ie . | | 28f. LOCATIO | N (Street or | nd Number | or Rural | Route Number, | _ |
| ETED | 4 Homicide determined | outoning, | with (Specify) | | | | | Uny or 10 | wn, State) | | | | |
| | 29e. CERTIFIER (Check only | YSICIAN: To the best of | my knowledge, death o | occurred at | the time, date | end place | end due | to the causele | end menr | ner es etel | led. | | |
| COMPL | | | | | | | | | | | | e) end menner ee stated. | |
| E C | 29b. SIGNATURE AND TITLE OF CERTIF | _ |) | _ | | - | ENSE NUI | | | | | (Month, Day, Year) | _ |
| 00 | | Car | 1-0 | | | | 3634 | | | 17 | 12 | 3/9/1 | |
| 2 | 30. NAME AND ADDRESS OF PERSON V | VHO COMPLETED CAU | SE OF DEATH NITEM 27 |) (Type, Print) |) | | 3034 | | | 1 | 1 | 1, | |
| | ADINATH A. PATIL | , M.D. | SHANTI ME | EDICAL | L CENT | CER. | LEON | IARDTON | N. M | ARVI. | AND | 20650 | |
| | 31. DATE FILED (Month, Day, Year) | | Pasignature welfor hardal | 1 | | | | THE TOW | ~ 1 | 44. | | 23020 | |
| | JUL 27 1994 | 4 Jacon do | mentarinandal | v | | | | | | | | | |

2834 33

and the second of the second of the second

KIRDS A TOLLOW BY A SECTION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| _ | | | | | | 111100 | | | | HEG. NO | , | | | |
|------------|--|--|---------------------------|----------------|---|--|---|---|-----------|--------------------------|-------------|--------------|---|--|
| | 1. DECEDENT'S NAME (First | , Middle, Last) | | | | | | | | 2. DATE OF DEATH | | | 3. TIME OF DEATH | |
| | GRACE | SUI | DER | | YE | RGAN | | | | Aug Aug | 7. 1 | 994 | 6:20 P M | |
| | 4. SOCIAL SECURITY NUME | | 5. SEX | 6. AGE (In | yrs. last birt | thday) IF UN | IDER 1 YEAR | IF UNDER | R 24 HRS. | 7. DATE OF BIRTH | , 1 | | PLACE (State or Foreign | |
| | 214-05-7805 | 5 | 1 🗌 M 2 💢 F | 25 | 95 Y | PS. MONTE | HS DAYS | HOURS | MIN. | (Month, Day, Year) | 100 | Country | 1) | |
| | 9a. FACILITY NAME (If not in | | treet and number) | |)) | gh C | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | | INTY OF D | PA | |
| œ | 13426 Wins | | , | | | | | | ON OF DE | Ain | | | | |
| 임 | RESIDENCE OF DEC | | 146 | | | Hagerstown | | | | | | Washington | | |
| <u> </u> | 10a. STATE | 10b. COUNTY | , | - | 10 | c. CITY, TOW | N OR LOCA | TION | | | | | 10d. INSIDE CITY | |
| DIRECTOR | MD | T. | LaVale | | | | | LIMITS? | | | | | | |
| | 10e. STREET AND NUMBER | | legany | | 101, ZIP CODE | | | | | T 100 CI | IZEN OF W | HAT COUNTRY? | | |
| FUNERAL | 504 A Stre | eet | | | 2 1 5 0 2 | | | | | log. Cr | | nai cookinii | | |
| <u> </u> | 11. MARITAL STATUS | J.S. ARMED | | | | | USA | | | | | | | |
| 로 | 1 Never Married 2 | 2 X NO | · | If yes, sp | pecify, Cuba | m, Maxica | IIC ORIGIN? (Specify Vi n, Puarto Rican, etc.) | C ORIGIN? (Specify Yes or No- 14. RACE - Black, 1 | | | | | | |
| B | 3 X Widowed 4 Divo | ES | | 1 🗌 YES | 2 A NO | Specify | | | Specif | White | | | | |
| | 15. DEC | Se DECEDI | ENT'S USUAI | COCUPATI | - | _ | | | | WILLE | | | | |
| | (Specify only | y highest grade | completed) | | (Give ki | ind of work do | ne during m | ost of working | ng | 16b. KIND OF BI | SINE SS/IN | DUSTRY | | |
| ا ټ | Elementary/Secondary (0 | 1-12) | College (1-4 or 5 | | | | | | | 0 | C1 - | 0- | | |
| COMPLETED | 17. FATHER'S NAME (First, M | (delete Last) | | 11 | Orme | r co- | owiter | | | | | ss Co | • | |
| | 1 | | | | | | ME (First, Middle, Maide | Sumame) | | | | | | |
| 8 | James Heni | | S T. | | | | | | | la Geiger | | | | |
| 2 | | | 0 | | | | | | | loute Number, City or To | | | | |
| | John Dick | | | _ | | e; Ha | gerstown, | | 2174 | | | | | |
| | 20a METHOD OF DISPOSIT | iON n 3 🗆 Rame | oval from State | | | DATE OF DISI | | | | | | Ctty or Tox | | |
| | 4 Donetion 5 Other | ery, cremalory or other place) ite Oak Cemetery 8/20 White | | | | | ite | Oak, | PA | | | | | |
| | 21. SIGNATUBE OF FUNERA | L SERVICE LIC | ENSEE | | 22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home | | | | | | | | | |
| | D(Land | 1 1 | 2 Mag | V Wa | 11 | v: - | | _ | | | | | | |
| ⊣ | 23. PART . Enter the d | seases, or c | complications the | t castant t | he death | Do not en | | erla | | | lanta a | | 1 Assessment | |
| | / shock, or h | eart fallure. | List only one csi | se on esc | h ilne. | | | , ac o. ay | mg, odo. | . as cardied or real | matory at | 1000, | Approximata Intsrvsi Batween | |
| | IMMEDIATE CAUSE (Fir disease or condition | nal | | 4 10 | 111 | 1 | 101 | 160- | 7 | | | | Onsat and Death | |
| | reaulting in death) | → , | a | 110 | BH | 7 | | (65) | | | | | | |
| | | | DUE TO | (OR AS A C | ONSEQUEN | NCE OF): | Dr leg Drseage | | | | | | | |
| 2 | Sequentially list conditi | lons. | b | CON | nery | // | 1-les | | sec | R | | | | |
| | if any, leading to Imme- cause. Enter UNDERLY | diste | DUE TO | TOR AS A C | ONSEQUEN | ICE OP): | | | | | | | | |
| HILICALION | CAUSE (Disease or Inju | | C. DUE TO | (OB 40 4 O | ONGEOUGL | 105.00 | | | | | | | | |
| = | that initiated eventa resulting in death) LAS | т П | DOE TO | (OR AS A C | ONSEQUEN | VCE OF): | | | | | | | | |
| S E | | | d | | | | | | | | | | | |
| AL C | PART II. Other significa | nt/condition | a contributing to | death but | not resul | not resulting in the underlying cause given in Part I. | | | | Part I. 24a, WAS A | AUTOPSY | 24b. | WERE AUTOPSY FINDINGS | |
| 5 | | 71 | 111 | MI | 11-0 | 3 | , | | | PERFO | RMEDI | 1 - 1 | AVAILABLE PRIOR TO COMPLETION OF CAUSE | |
| EDIC | | LA V | 7/ | 1/10 | 19/ | - | | | | 1 ☐ YES | 2 NO | | OF DEATH? | |
| Σ | | / | | - | | | | | | — 1 | 7 | | 1 YES 2 NO | |
| PHYSICIAN: | DID TOBACC | | CONTRIBUT | E TO | CAUSE | OF DE | EATH | YES [|] NO | D Z | | | | |
| 3 | 25. WAS CASE REFERRED TO EXAMINER? | O MEDICAL | HOSPITAL: | | | ОТН | | LACE OF D | EATH (Che | ick dnly one) | | | | |
| 2 | 1 TES 2 NO | | 1 Inpatient 2 | ER/Outpati | lent 3 🗆 C | | | ne 5 🗆 Re | sidenca | 6 Other (Specify) | | | | |
| 5 | 27. MANNER OF DEATH | | 26a. DATE OF (Month, E | | 26 | b. TIME OF | 26c. IN. | JURY AT ORK? | | 28d. DESCRIBE HOW | INJURY O | CURED | | |
| - ∥ | | Pending Investigation | | -,,, | | M | | YES 2 | NO | | | | | |
| 2 | 0 0 0 0 1 1 1 1 | Could not be | 26a. PLACE C | F INJURY - | At home, 1 | ferm, street, | tactory, offic | en . | | 26t. LOCATION (Street | | r or Rural R | oute Number, | |
| 3 | | determined | | ato: (opocity) | , | | | | | City or Town, State | , | | | |
| COMPLE | 29a. CERTIFIER 1 N CERT | IFVING PHYSIC | CIAN: To the best of | my knowled | ton death o | nonuread at th | no timo dete | and alone | and due | to the ceuse(a) and me | | | | |
| Ē | | | | | | | | | | | | | and manner as stated, | |
| 3 | | | | _ | | | ту ориноп, с | | | | na aue to t | ne cause(a) | and manner as stated, | |
| 4 | 29b. SIGNATURE AND TITLE | A / A | 11 11 | P | | | | 29c. LICI | ENSE NUM | BER | 29d. DA | TE SIGNED | (Month, Day Year) | |
| 5 | | 11,141 | 1/Chaill | 4 | | | | | 193 | 18 | | 8/ | 18/94 | |
| | 30. NAME AND ADDRESS OF | | | _ | | | | | | | | 1 | 1/ | |
| | | | .7 Oldtow | | | umber. | land, | MD | 2150 |)2 | | | | |
| | 31. DATE FILED (Month, Day, | Year) | 32. REGIŞTRA | R'S SIGNAT | URE | | | | | | | | | |
| | ALIC 9 / 1 | NOO | Laurele | or-Rand | all the | | | | | | | | | |

v i ha feli elemente de la completa del completa de la completa de la completa del completa de la completa del la completa del la completa de la completa de la completa de la completa de la completa de la completa de la completa de la completa de la completa de la completa de la completa de la completa del la completa de la completa del la completa de la completa del la complet

DIVISION OF VITAL REGORDS,

TO THE HOSPITAL OR ATTENDING PHYSIDAN. The law migures it was certificate be executed within 2s hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FLIMERAL DIRECTURE After the commercian has been sized by the ground physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled worm 72 hours after death with the Same Dept. of Health and Indian or other traumatic event, the medical examiner must be notified at once.

| STATE OF | MARYLAND / | DEPARTMENT | OF HEALTH | AND | MENTAL | HYGIENE |
|----------|------------|------------|-----------|------|--------|---------|
| | C | ERTIFICATE | OF DEAT | TH . | | REG NO |

| REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF MONTH | EG. NO. | | | | | |
|--|--|--|--|--|--|--|
| | DEATH 3. TIME OF OEATH | | | | | |
| DELORES NORMA ARTIS SEPTE | MBER ^{AY} 3, 1994 1:31A м | | | | | |
| 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthdey) IF UNDER 1 YEAR IF UNDER 14 HRS. 7. DATE OF 8 (Month, De | B. BIRTHPLACE (State or Foreign Country) | | | | | |
| 216-05-9516 1 M2 XF 64 YRS. 1-2 | -30 md | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH | | | | | |
| THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY | | | | | | |
| THE JOHNS HOPKINS HOSPITAL RESIDENCE OF DECEDENT 100. STATE 100. COUNTY 100. CITY, TOWN OR LOCATION 100. CITY, TOWN OR LOCATION 100. CITY, TOWN OR LOCATION | 10d, INSIDE CITY | | | | | |
| a md BAITO. | LIMITS? VES 2 ☐ NO | | | | | |
| 104. STREET AND NUMBER 107. ZIP CODE | 10g, CITIZEN OF WHAT COUNTRY? | | | | | |
| 106. STREET AND NUMBER 807 N. Mont Fond Auc 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF HISPANIC ORIGIN? (S. P. Vertor Ricar) 14. Name Married 15. Was Decendent of Hispanic Origin? (S. P. Vertor Ricar) 15. Was Decendent of Hispanic Origin? (S. Vertor Married) 16. STREET AND NUMBER 21. 21. 20. 5 17. Name Married 18. Was Decendent of Hispanic Origin? (S. Vertor Married) 19. Name Married 19. STREET AND NUMBER 106. STREET AND NUMBER 21. 20. 5 11. Married 19. STREET AND NUMBER 107. ZIP CODE 21. 20. 5 11. Married 19. STREET AND NUMBER 108. STREET AND NUMBER 109. STREET AND NUMBER 109. STREET AND NUMBER 109. STREET AND NUMBER 109. STREET AND NUMBER 109. STREET AND NUMBER 109. STREET AND NUMBER 109. STREET AND NUMBER 109. STREET AND NUMBER 109. STREET AND NUMBER 109. STREET AND NUMBER 109. STREET AND NUMBER 109. STREET AND NUMBER 11. MARRIED 11. MARRIED 12. WAS DECENDENT OF HISPANIC ORIGIN? (S. S. S. S. S. S. S. S. S. S. S. S. S. S | 21.5 | | | | | |
| 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF HISPANIC ORIGIN? (S 14. WAS DECEMBENT OF HISPANIC ORIGIN? (S 15. WAS DECEMBENT OF HISPANIC ORIGIN? (S 16. WAS DECEMBENT OF HISPANIC ORIGIN? (S 17. WAS DECEMBENT OF HISPANIC ORIGIN? (S 18. WAS DECEMBENT OF HISPANIC ORIGIN? (S 19. WAS DECEMBEN | | | | | | |
| 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: | Specify: | | | | | |
| | D OF BUSINESS/INDUSTRY | | | | | |
| (Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) (Give kind of work done during most of working life. Do NOT use retired.) | | | | | | |
| Housewife | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secopdary (0-12) College (1-4 or 5+) 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refired.) HOUGH IN 18. MOTHER'S NAME (First, Middle, Last) 17. FATHER'S NAME (First, Middle, Last) | e, Maiden Surname) | | | | | |
| TAMES FRISH EDNA | M. BA115 | | | | | |
| 196. MAILING ADDRESS (Street and Number or Rural Route Number) | , | | | | | |
| FILTERE FILLIS 103 11 POFT ST BA | 12. md 21205 | | | | | |
| 20a_BETHOD OF DISPOSITION 1 | 20c. LOCATION — City or Town, Stata | | | | | |
| 21. SIGNATURE FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | BAHT, nu. | | | | | |
| Potis De un | 2/205 | | | | | |
| Betts - unexal/ | me 11294. CAroling | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac shock, or haert feliure. Liet only one ceuse on each line. | or reapiratory arrest, Approximate interval Between | | | | | |
| IMMEDIATE CAUSE (Final | | | | | | |
| disease or condition | | | | | | |
| resulting in death) e. SACTEVEIAL DEPSIS | Onset and Dawth | | | | | |
| resulting In death) e. SACTEVELAC DEPSIS DUE TO (OR AS A CONSEQUENCE OF): | Onset and Dauth | | | | | |
| resulting in death) e. SACTEVELAC DEPSIS DUE TO (OR AS A CONSEQUENCE OF): | Onset and Darth 19 bays 20 bays | | | | | |
| resulting in death) e. SACTEVELAC DEPSIS DUE TO (OR AS A CONSEQUENCE OF): | 19 DAYS 20 DAYS | | | | | |
| resulting In death) e. SACTEVELAC DEPSIS DUE TO (OR AS A CONSEQUENCE OF): | 19 DAYS 20 DAYS | | | | | |
| resulting in death) e. SACTEVELAC DEPSIS DUE TO (OR AS A CONSEQUENCE OF): | 19 DAYS 20 DAYS | | | | | |
| POLY TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): CHRODIC OBSTRUCTIVE PURMANA DUE TO (OR AS A CONSEQUENCE OF): d. | 19 DAYS 20 DAYS | | | | | |
| PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuee given in Part I. 24s | 20 DAYS 20 DAYS 20 DAYS 20 DAYS 20 DAYS 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE | | | | | |
| PART ii. Other significent conditions contributing to deeth but not resulting in the underlying ceuee given in Part i. | 20 DAYS 20 DAYS 20 DAYS 20 DAYS 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO | | | | | |
| PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuee given in Part i. | 20 DAYS 20 DAYS 20 DAYS 20 DAYS 20 DAYS 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | |
| PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuee given in Part i. | 20 DAYS 20 DAYS 20 DAYS 20 DAYS 20 DAYS 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | |
| PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuee given in Part i. | 20 DAYS 20 DAYS 20 DAYS 20 DAYS 210 YIS 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DID TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONS | 20 DAYS 20 DAYS 20 DAYS 20 DAYS 210 YIS 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO PART II. Other algnificent conditione contributing to deeth but not resulting in the underlying ceuee given in Part I. 24a DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | 20 DAYS 20 DAYS 20 DAYS 20 DAYS 20 DAYS 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): CHRODIC OR STRUCTURE PURCHASE DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQU | 20 DAYS 20 DAYS 20 DAYS 20 DAYS 20 DAYS 210 YIES 24b, WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH Natural 5 Pending Investigation (Month, Dey, Veer) 28. DATE OF INJURY WORK? 1 VES 2 NO 29. PLACE OF INJURY AT WORK? 1 VES 2 NO 29. PLACE OF INJURY AT WORK? 1 VES 2 NO 29. PLACE OF INJURY AT WORK? 1 VES 2 NO 29. PLACE OF INJURY AT WORK? 1 VES 2 NO 29. PLACE OF INJURY AT WORK? 1 VES 2 NO 29. PLACE OF INJURY AT WORK? 1 VES 2 NO 29. PLACE OF INJURY AT WORK? 1 VES 2 NO 29. PLACE OF INJURY AT WORK? 1 VES 2 NO 29. PLACE OF INJURY AT WORK? 1 VES 2 NO 29. PLACE OF INJURY AT WORK? 1 VES 2 NO 29. PLACE OF INJURY AT WORK? 1 VES 2 NO 29. PLACE OF INJURY AT WORK? 1 VES 2 NO 29. PLACE OF INJURY AT WORK? 1 VES 2 NO 29. PLACE OF INJURY AT WORK? 1 VES 2 NO 29. PLACE OF INJURY AT WORK? 1 VES 2 NO 29. PLACE OF INJURY AT WORK? | 20 DAYS 20 DAYS 20 DAYS 20 DAYS 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 Street and Number or Rural Route Number, wri, State) | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): CHRODIC OR STRUCTURE PURCHASE DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQU | 20 10 18 20 10 18 20 10 18 20 10 18 20 10 18 21 | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease or injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO PART II. Other algnificent conditione contributing to deeth but not resulting in the underlying ceuee given in Part i. 24. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO EXAMINERY 1 | 20 10 18 20 10 18 20 10 18 20 10 18 20 10 18 21 | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONS | 20 DAYS 20 DAYS 20 DAYS 20 DAYS 20 DAYS 210 YIS 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO No Street and Number or Rural Route Number, wirt, State) 29d. DATE SIGNED (Month, Day, Year) | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONS | 20 DAYS 20 DAYS 20 DAYS 20 DAYS 20 DAYS 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 OSTRORY AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 OSTRORY AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 OSTRORY AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 OSTRORY AWAILABLE PRIOR TO CAUSE OF DEATH. | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONS | 20 DAYS 20 DAYS 20 DAYS 20 DAYS 20 DAYS 210 VIS 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Recity) 25E HOW INJURY OCCURED N (Street and Number or Rural Route Number, wrr., State) 29d. DATE SIGNED (Month, Day, Vear) 29d. DATE SIGNED (Month, Day, Vear) | | | | | |

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FOR 1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO

| | | REGISTRAR | | CERTIF | ICATE OF | DEATH | REG. NO | 5 . | | | | |
|---|--------------|---|--|---------------------------------|-------------------------------------|----------------------|---|-----------------|--------------------------|--|----------|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | - | | TIME OF DEA | TN | |
| | | ISSAC AKTN | - ADKINS | | | | 8 8 | | 94 4 | :00 | P M | |
| - | 8 | 4. SOCIAL SECURITY NUMBER | | (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | BIRTNPLA | CE (State or 5 | Foreign | |
| | - 8 | 218-16-6621 | 1 □, M 2 □ F 8 | 9 YRS. | MONTHS DAYS | HOURS MIN. | 5720/05 | ; - | MD. | | o. o.g., | |
| should | l # | 9a. FACILITY NAME (If not institution, give si | treet and number) | | 96. CITY, TOWN | OB LOCATION OF O | | | Y OF DEATH | | | |
| en | ۳. | 3003 BAVVILLE DE | | | BAL | CIMORE OF O | | | | | | |
| 1. 2. | 5 | RESIDENCE OF DECEMENT | | | | | | | | | | |
| ages | DIRECTOR | 10e. STATE 10b. COUNTY | 7 | 10c. CIT | TY, TOWN OR LOCA | ATION | | I. INSIDE CITY | Y | | | |
| permit. Pages | | MD. 3919 X | BALTO | MYS | XXXXEMX | RM. CHAS | <u> </u> | | 1 [| YES 2 | NO | |
| t per | RAL | 10e. STREET AND NUMBER | | | - 10 | Of. ZIP CODE | _ | 10g. CITIZE | N OF WHAT | COUNTRY? | | |
| 020 physician. burial-transit | FUNER | 3919 MISTYVIEW | RD. | | | 21220 | | LISA | | | | |
| 020 physician burial-tra | 品 | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER II FORCES? 1 YES | 2 NO | | | NIC ORIGIN? (Specify Young, Puerto Rican, atc.) | 18 or No— 14 | I. RACE — A Black, Wh | American Indi nita, atc. | len, | |
| 15-00 ending p as the b | BY | \$ ☐ Widowed 4 ☐ Divorced | IF YES, GIVE WAR OR D. | ATES | 1 - YE | S 2 NO Speci | fy: | | SPBLA | CK | | |
| | 6 | 15. DECEDENT'S EDUC | | | USUAL OCCUPATI | | 16b, KIND OF BI | JSINESS/INDUS | | | | |
| 212 | Щ | (Specify only highest grade Elementary/Secondary (0-12) | Completed) College (1-4 or 5 +) | (Give kind of life. Do NOT u | work done during m ise retired.) | ost of working | | | | | | |
| | 절 | | | LABO |)RER | | | | | | | |
| AND the hospit detached once. | COMPLET | 17. FATNER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | AME (First, Middle, Maide | n Sumame) | | | | |
| N D D D | ш | ZANY ADKINS | | | | UNKNOWN | | | | | | |
| MARYLAND retained by the hospit should be detached notified at once. | TO B | 19a. INFORMANT'S NAME (Type/Print) | - | | | | Route Number, City or To | | | | | |
| | - | MAXINE LEE | | 3919 | MISTYV | IEW RD. I | BALTO, MD. | 21220 | | | | |
| BALTIMORE, ser death. Page 6 may be the funeral director, page wa! | | 20a. METNOD OF DISPOSITION 1 KBurlai 2 Cremation 3 Ramo | oval from State cen | PLACE AND DATE | OF DISPOSITION (N | lame of | | OCATION — CIN | y or Town, S | State | | |
| SALTIMOR death. Page 6 ma e funeral director, ia al. | | 4 Donation 5 Other (Specify) | | t. Steph | | | 9-2-94 | | | | | |
| ALTIM death. Page tuneral direct. | - 1 | 21. BIGHATURE OF FUNERAL SERVICE LIC | PHSEE | | | ND ADDRESS OF FA | | | | | 11.15 | |
| 0 = 0 | | Charles () | 1/25 | 00 | WM. C | BROWN (| COMMUNITY | FH 120 | 6 W. | NORTH | AVE | |
| Burs after in by the removal | | 25: PART I. Enter the diseases or o | omplications that ceused | tha death. Do | not enter the me | ode of dying, aud | ch aa cerdiac or resp | piratory arrea | it, | Approxim | ata | |
| F60, ed within fours after completely filled in by the I, cremation, or remove event, the medical | | IMMEDIATE CAUSE (Finel | List only one ceuse on e | | 1 |) , | 0. | | i | Onset and | | |
| tely fi | | disease or condition reaulting in death) | · /n | Maslo | ulic P | rosyali | e Care | MARI | 100 | | | |
| 68760, ecuted within nd completely burial, cremat atic event, i | | OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| | Z | Sequentially list conditions, if any, leading to immediate Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| × : = = = | ERTIFICATION | | | | | | | | | | | |
| m 7 2 - | 윤 | CAUSE (Disease or injury that initiated exerts DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| P.O. h certific anding p Hygiene or othe | Ē | that initiated events reaulting in deeth) LAST | 502 10 (011 A3 A | CONSEQUENCE | ej. | | | | i | | | |
| the state | <u> </u> | | d, | | | | | | | | | |
| ORDS, that the dea ed by the att th and Menta any injury, | A | PART ii. Other significent conditions | s contributing to deeth b | ut not reaulting | in the underlyin | ig ceuse given in | | N AUTOPSY | | E AUTOPSY F | | |
| ECOR juires that signed by Health an | EDICAL | | | | | | 1 - YES | | COM | LABLE PRIOR IPLETION OF (DEATH? | | |
| REC requires seen sign of Heali | ME | | | | | | | | | YES 2 | NO | |
| . 3 5 00 | | DID TOBACCO USE CONTR | RIBUTE TO CAUSE O | F DEATH YE | S NO | UNCERTAI | N 🗆 | | | | | |
| # # # # # | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEA | TH (Check only one) |) | | | | | | |
| F VIT SICIAN: The certificate the State to ritem | YSI | 1 TYES 2 NO | 1 Inpatient 2 ER/Outp | etlent 3 🗆 DOA | | ne 5 🗆 Residence | 6 Other (Specify) | | | | | |
| OF VI PHYSICIAN: this certifica with the St with the St | РНҮ | 27. MANNER OF DEATH 1 Natural 5 Pending | (Month, Day, Year) | 28b. TIM | JURY WO | JURY AT ORK? | 28d. DESCRIBE HOW | INJURY OCCUP | AED | | | |
| Zafe | à l | 2 Accident Investigation | | | | YES 2 NO | | | | | | |
| | | 3 Suicide 6 Could not be 4 Nomicide detarmined | 28e. PLACE OF INJURY building, etc. (Spec | - At nome, term, | street, fectory, offic | CO . | 28f. LOCATION (Street City or Town, State | and Number or | Rural Route | Number, | | |
| DIVISION ATTEN DIRECTOR: hours after them 28 i | 10 N | 00.00000000 | | | | | | | | | | |
| 로 크 오 누 | COMPL | (Check only | CIAN: To the best of my know | | | | | | | | | |
| HOSPITAL FUNERAL within 72 | 8 | 2 MEDICAL EXAMINER | R: On the basis of examination | n and/or investigation | on, in my opinion, o | death occured at the | time, data and place, a | nd dua to the c | ause(s) and | manner ss s | stated. | |
| HE HE FI | BE | 296. SIGNATURE AND TITUE OF CERTIFIER | .10 | | | 29c. LICENSE NUI | MBER / | 29d. DATES | IGNED (Mgr | ith, Day, Year) | | |
| TO THE HOSPITA TO THE FUNERA De filed within 7 IMPORTANT: 1 | 0 | 1 / VUI | _ /// | | | 11/8 | 578 | / / | 114 | 9 | | |
| | - | 30. NAME AND ADDRESS OF PERSON WHO |) COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type | , Print) | | 199 | | 1 | 7 | | |
| | | 21 DATE FILED (March 2 V) | | | | | | | | | | |
| | | SEP 0 8 1994 | A STEELS OF LAND | Graps | | | | | | | | |

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| | | 1 - STATE REGISTRAR | STATE OF MARYLA | | RTMENT OF H | | MENTAL | HYGIENE REG. NO. | | | | |
|--|--------------|--|---|-------------------------------|--|---|----------------------------|----------------------------------|---|--|--|--|
| | 1,7808/40 | 1. DECEDENT'S NAME (First, Middle, Last) STEWART | Dr. Stuart B. ABRA | Bernard 1 | Abrams | | 2. DATE O MONTH AUGI | DAY | , 1994 | 3. TIME OF DEATH 1 03:38 A M | | |
| Pi | | 4. SOCIAL SECURITY NUMBER 219-40-5823 | 1 🗀 M 2 🗆 F | n yrs. lest birtnday) 51 YRS. | MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | MAY | Day, Year) 1, 1943 | MA | THPLACE (State or Foreign ntry) RYLAND | | |
| 2, 3 should | стоя | 9a. FACILITY NAME (If not institution, give sti SHOCK TRAUMA RESIDENCE OF DECEDENT | eet and number) | | | FIMORE | EATH | 9c. | COUNTY OF | DEATH | | |
| L. Pages 1. | DIREC | 10e. STATE 10b. COUNTY MARYLAND | BALTIMORE | 10c. CI | TY, TOWN OR LOCAT | BALTIN | MORE | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | |
|). insit permit. | ERAL | 100. STREET AND NUMBER 3015 KATEWOOD CCUI | RT | | | 21209 | 10 | 10g | SA | | | |
| 215-0020 attending physician. ise as the burial-transit | BY FUNI | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 14 YES | 2 NO | If yea, sp | ENDENT OF HISPA ecity Cuban, Maxica 2 NO Specific | en, Puerlo Ric | | ICE — American Indian, ack, Whita, atc. ec/ly: WHITE | | | |
| 12 al or 12 al | PLETED | 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) | | (Give kind of life. Do NOT | 8a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DENTIST | | | DENTIS | | | | |
| YLA by the be der | E COMP | 17. FATHER'S NAME (First, Middle, Last) SAMUEL | 3+ | ABRAMS | MULISIT | 18. MOTHER'S NA | ime) | | | | | |
| MAR e retained e 5 should notified | TO B | 19a, INFORMANT'S NAME (Type/Print) MRS. SHELLY GOLDS | EKER | | 19b. MAILING ADDRESS (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 16 VELVET VALLEY COURT OWINGS MILLS, MD 21117 | | | | | | | |
| Page 6 may be al director, page | | 20a, METHOD OF DISPOSITION 1 Paurial 2 Cremation 3 Ramo 4 Donation 5 Other (Specify) | | | OF DISPOSITION (NA | | ROSEDA | | on — city or -94 RO | Town, State SEDALE, MD | | |
| death. truer truer e funer li | 1 | 21. SIGNARLINE OF FUNERAL SERVICE LIG | 1 7 | ris | SOL | LEVINSON | & BR | | | E, MD 21215 | | |
| within 24 hours aft mpletely filled in by cremo cremation, or remo | | IMMEDIATE CAUSE (Final | omplications that deused list only one cause on as DUE TO (OR AS A | ach line. | not enter the mo | de of dylng, suc | ch as cardle | c or reapirator | y arreat, | Approximate / interval Between Onset and Death | | |
| P.O. BOX 68' th certificate be execute ending physician and ci I Hygiene prior to buria or other traumatic | ERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d | | | | | | | | | | |
| CORD; lires that the signed by the Health and M ws any Inju | MEDICAL C | PART II. Other significent conditions | | | | | _ | PERFORMED | ? | 4b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO | | |
| law law bept. 23 | CIAN: | DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | _ | TES NO CATH (Check only one) OTHER: |] UNCERTAI | N 🗆 | | \perp | , | | |
| ON STENDING PHYSICIAN: The OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate hours after death with the State Clem 28 is marked, or litem | PHYSICIAN | 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | 1 Inpetient XI ER/Output 26a. DATE OF INJURY (Month, Day, Year) 08-31-14 | 28b. TII | 4 Nursing Hom ME OF 28c. INJ IJURY WO | RK? | | Specify) | Y OCCURED | CON 11056N | | |
| TTENDING TOR: After after death 28 Is ma | LED BY | 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined | 28s. PLACE OF INJURY building, etc. (Speci | - At home, farm. | streat, factory, offic | r | | TION (Street and No Town, State) | | L DRIVE, MD | | |
| 4 4 2 E | COMPLET | anal . | CIAN: To the best of my knowle | edge, daath occur | red at the time, data | | to the cause | (s) and manner a | a stated. | | | |
| TO THE HOSPITAL TO THE FUNERAL be filed within 72 IMPORTANT: If | BE | 29 SIGNATURE AND TITUTION CERTIFIER | W.Sal | - | | 29c. LICENSE NUI | | 29d | . DATE SIGNE | ED (Month, Day, Year) ST 31, 1994 | | |
| | 10 | 30. NAME AND ADDRESS OF PERSON WHO MARLO F. GOLVE | COMPLETED GAUSE OF DEL | | , , | | | | | and 21201 | | |
| | | 31. DATE FILED (Month, Day, Year) SFD 0 8 1994 | fille allies | Mardelle | | | | | | | | |

608.38

STATE REGISTRAR

30. NAME AND AODRESS OF

1994

MAKIO

SEP 0 8

1 -

YEAR 94

9c. COUNTY OF DEATH

10a. CITIZEN OI

3. TIME OF DEATH

16d, INSIDE CITY

WHAT COUNTRY?

t TYES 2 NO

intarval Between

Onset and Death

24b. WERE AUTOPSY FINDINGS

AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?

1 - YES 2 - NO

SEPT 7,1994

111 Penn Street, Baltimore, Maryland 21201

Pa.

1:50

B. BIRTHPLACE (State or

ITEMS: 23 PART I, 27, PER MEO FILM G-715 9/26/94 t.t.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

t. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH SHELIA 06 BOWIE SEPT 6. AGE (In yrs. 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH -72-9 1 M 2 YRS. Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 28 N.BERNICE STREET BALTIMORE CITY RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN, OR LOCATION Tore permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 120 use as the bunal-transit ours after death. Page 6 may be retained by the hospital or attending physician. 11. MARIJAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify **MARYLAND 21215-0020** If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Married 2 Merried BY 3 Widowed 4 Divorced COMPLETED 15. OECEDENT'S EDUCATION 16e. DECEOENT'S USUAL OCCUPATION
(Give kind of work done during most (Specify only high Elementary/Secondary (0-12) funeral director, page 5 should be detached for ege (1-4 or 5 +) once. 17. FATHER'S NAME (First, Midple, Ħ BE notified 2 pe BALTIMORE, Buriel 2 Cremetion 3 Removal from State 206. PLACE AND must 4 Donation 5 Other (Specify) examiner MTURE OF FUNERAL SERVICE LICENSEE 1 attending physician and completely filled in by the intra Hygiene prior to burlal, cremation, or removal. medical 23. FART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final 鲁 disease or condition resulting in dasth) CHRONIC ALCOHOLISM event, BOX 68760, OUE TO (OR AS A CONSEQUENCE OF): OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if sny, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF): P.0. that initiated events resulting in death) LAST the atter Injury. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY has been signed by to Dept. of Health and PERFORMED? shows any 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) certificate h. OTHER:
4 | Nursing Home | 5 | | Residence | 8 | Other (Specify) HOSPITAL: 1 XYES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED this c marked, 1 XNetural 1 YES 2 NO ΒY After 2 Accident Investigation 28e. PLACE OF INJURY — At home, lerm, street, factory, office building, etc. (Specify) 3 Sulcide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) L DIRECTOR: A hours after d 99 8 Could not be datermined COMPLETED 28 4 Homicide Hem 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best place, death occurred at the time, date end place, and due to the cause(e) and manner ee stated. HOSPITAL FUNERAL within 72 I = TO THE FUNERAL be filed within 72 IMPORTANT: II 2 X MEDICAL EXAMINER: On the best of water ion end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end manner as stated. 96 SIGNATURE AND TITLE OF CERT 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) THE THE FIND O.C.M.E. 9 OF DEATH (ITEM 27) (Type, Print)

32. REGISTRÁR'S

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REG. NO.

FOR STATE REGISTRAR

BOX 68760, DIVISION OF VITAL RECORDS, P.O. OR ATTENDING PHYSICIAN: The law

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funeral director, the in by lled completely attending physician peen has

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH
MONTH Sep 3 1994 3. TIME OF DEATH BLUM PAUL ALBERT 2:46 pm 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Yea IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign 1 X M 2 - F DAYS HOURS 64294 103-07-7933 88 YRS. Sept 18, 1905 MO for use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (if not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Saint Joseph Hospital Towson, Maryland Baltimore RESIDENCE OF DECEDENT 10e STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Towson 1 YES 2X NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8119 Bellona Avenue 21204 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuben, Mexicen, Puerto Ricen, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE - American Indian, Black, White, etc. FORCES? 1 YES 2 2 X NO 1 Never Married 2 Merried BY Specify: 3 🔀 Widowed 4 🗌 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION

(Chee kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade co (Give kind of work done life. Do NOT use retired.) Elementery/Secondary (0-12) 12 Years College (1-4 or 5+) Salesman Improvement Home once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surneme) 듆 Albert Harriett B1um Boyd BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 8119 Bellona Ave. Baltimore, MD Mrs. Wendy Lyons 21204 be 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 1

Burlel 2 ☐ Cremetion 3 ☐ Removal from State Donetion 5 Other (Specify) Meadowridge Memorial Park 19-6 Elkridge, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, 8728 Liberty Rd. Randallstown, MD 21133 medicai 23. PART 1 Enter the dieeeses, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, Dr heart failure. List pniy Dne ceuse pn each line. interval Batween 0 IMMEDIATE CAUSE (Final Onset and Death cremation, the disease or condition a. CARDIOMYOPATHY UNK resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): n and com to burial, **L. VENTRICULAR ARRHYTHMA** UNK CERTIFICATION Sequentially list conditione, if any, leading to immediate Drior cause. Enter UNDERLYING CAUSE (Diseese or injury other 1 Hygiene DUE TO (OR AS A CONSEQUENCE DF): thet initieted events resulting in desth) LAST 6 signed by the atten Health and Mental h PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO 1 TES 2 NO 50 PHYSICIAN: Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) item certificate to the State EXAMINER? HOSPITAL: OTHER: 1 TES 2 NO Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c marked, 1 Natural 2 Accident 5 Pending 1 YES 2 NO BY After investigation 28e. PLACE OF INJURY — At home, farm, strast, factory, office building, atc. (Specify) DIRECTOR: An hours after desitem 28 is n 3 Suicide 26f. LOCATION (Street end Number or Rural Route Number, City or Town. State) ETED. 6 Could not be determined 4 Homicide 72 hours : 29e. CERTIFIER (Check only one) OMP 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, and due to the ceuse(e) end menner ee stated. 2 MEDICAL EXAMINER: Do 1 on and/or investigation, in my opinion, death occured at the time, date end pleca, and due to the ceuse(a) and manner ee stated. 29b. SIGNATURE AND TITLE OF 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D15452 30. NAME AND ADDRESS OF PERSON W/O COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C.TIMOTHY BESSENT, M.D., ST. JOSEPH HOSPITAL, 7620 YORK ROAD, TOWSON, MD. 21204 32. REGISTRAPS SIGNATURE 31. DATE FILED (Month, Day, Year) 1994

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

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BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 should

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DIVISION OF VITAL RECORDS, P.O.

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296. SIGNATURE AND THE OF CERTIFIER

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First Middle Leat) 3. TIME OF DEATH 04DAY O MONTH 06:22 PM BLACKMON. JR CLEVELAND Ŧ. ONZO 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 5. SEX 6. AGE (In yrs. last birthday) B. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS 1 M 2 F 58 YRS. 213-32-8642 10/03/35 S.C 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH A.A. COUNTY DIRECTOR GLEN BURNIE NORTH ARUNDEL HOSPITAL ASSOCIATION RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 10b. COUNTY 10d. INSIDE CITY LIMITS? MD. A.A. COUNTY GLEN BURNIE 1 YES 2X NO 10s. STREET AND NUMBER FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 249 THOMPSON AVENUE 21061 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married 1 YES 2X NO IF YES, GIVE WAR OR DATES Specify: BY 3 Widowed 4 W Divorced BLACK COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY during most of working (Specify only highest grade Give kind of work done to Do NOT use retired.) College (1-4 or 5 + Elementary/Secondary (0-12) SELF EMPLOYED FUEL OIL COMPANY 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) ELIZABETH CLEVELAND T. . BLACKMON, SR. MCGRIFF notified at BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 ELIZABETH GILLIAM WINSOR HILL APT 204 BALTO, MD.21207 ê 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must X Buriel 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) MARYLAND NATIONAL MEM 9/10 LAUREL, MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY BETTS FUNERAL HOME examiner 1129 N. CAROLINE ST. BALTO, MD21213 medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert fallure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final etensive intercerebral temorrhogo
DUE TO (OR AS A CONSEQUENCE OF): the disease or condition 9/1/94 Extensive event. reaulting in daeth) 4 days Hyperteus on. traumatic CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING other t CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF) that initieted events resulting in death) LAST PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? WAILABLE PRIOR TO any COMPLETION OF CAUSE OF DEATH? 1 TYES 2 DING shows : 1 YES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) 1 YES 2 NO 1 Impatient 2 ER/Outpatient 3 DOA 0 27. MANNER OF BEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be DIRECTOR: J COMPLETED 28 4 Homicide Item 29s. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and menner se stated. (Check only one) 2 MEDICAL EXAMINER: On the beels of exemination Atte den

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)
GURMEET SAWHNEY, M.D./325 HOSPITAL DRIVE, #202/GLEN BURNIE, MARYLAND

2. REGISTRAPI SIGNATURE

29c. LICENSE NUMBER

D44973

29d. DATE SIGNED Month, Day, Year)

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350 3 8 1924 West also and Rode

| TO BE COME | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION |
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| examiner must be notified at once. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
| al. | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal. |
| he funeral director, page 5 should be detached | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached |
| ir death. Page 6 may be retained by the hosp | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death centificate be executed within repart after death. Page 6 may be retained by the hosp |
| | |

| | FOR STATE | TATE OF MARYLAND / (| | | | MENTAL HYGIEN | E | | | |
|--------------------|---|--|---|------------------------------------|---------------------|--|---------------|----------------------|----------------------|----------|
| | REGISTRAR | CE | RTIF | CATE OF | DEATH | REG. NO | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH MONTH D | AY 1 | EAR 3. | TIME OF DE | ATH |
| | KANAKAN Sister | Raphael Bruckr | ner | | | August 30 | | | 8:50 | A.M.M |
| | 4. SOCIAL SECURITY NUMBER 5. S | SEX 6. AGE (In yrs. last | birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8 | DIRTHPLA Country) | CE (State or I | Foreign |
| | 380-52-9915 | □ M 2 □XF 91 | YRS. | MONTHS DAYS | HOURS MIN. | Oct. 20, | 1902 | | adeln | hie P |
| | 9e. FACILITY NAME (If not institution, give street a | and number) | | 96. CITY, TOWN C | R LOCATION OF DE | | 9c. COUNT | | | 11391 |
| 2 | Villa St. Michael | | | Emmits | hura | | Ema | 1 | 1. | |
| K | RESIDENCE OF DECEDENT | | | Limit | ourg, | | riec | leric | K | |
| DIRECTOR | 10a. STATE 10b. COUNTY | | 10c. CITY | , TOWN OR LOCAT | ION | | | 10- | I. INSIDE CIT | TY |
| ā | Maryland Frederi | ick | En | mitsbur | g | | | 1 (| YES 2 | NO |
| 4 | 104. STREET AND NUMBER | | | | ZIP CODE | | 10g. CITIZE | N OF WHA | COUNTRY? | |
| FUNERAL | 333 South Seton Ave | anue | | | 21727 | | U.S. | ٨ | | |
| <u> </u> | 11. MARITAL STATUS 12. | WAS DECEDENT EVER IN U.S. ARM | | 13. WAS DEC | | IIC ORIGIN? (Specify Yes | | - | American Inc | Sian. |
| ВҰ | | FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | 0 | If yes, sp | | n, Puerto Rican, etc.) | | Black, W Specify: | | , |
| | 15. DECEDENT'S EDUCATIO (Specify only highest grade comp | | EDENT'S | USUAL OCCUPATION | ON | 16b. KIND OF BU | SINESS/INDUS | TRY | | |
| ᄪ | | | Do NOT us | rork done during mo e retired.) | st of working | Religio | us Con | muni | ty | |
| 릴 | Col | llege 5+ Tea | cher | de . | | Daughte | rs of | Char | ity | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Malden | Surname) | | | |
| S | Joseph T. Bruckner | r | | | Emma l | Halberstad | t | | | |
| 00 | 19e. (NFORMANT'S NAME (Type/Print) | | MAILING | ADDRESS (Street a | | Route Number, City or Tow | | nde) | | |
| 2 | Sister Camilla Han | | | | | Emmitsburg | | 217 | 2.7 | 1.73 |
| | | 20h PLACE O | E DISPOS | ITION (Name of one | nelens ommetons or | 200.10 | CATION OF | as Tama | State | |
| | 20s METHOD OF DISPOSITION 1 X Buriel 2 Cremation 3 Removal I 4 Donation 5 Other (Specify) | Irom State St other place | OSAT | h's Pr | ovincia | 1 House | Emm i f | chi | ra MI | , |
| | 21, SIGNATURE OF FUNERAL SERVICE LICENSE | FF N | 1900 | 20 NAME AN | D ADDRESS OF FAI | CL HOUSE | Dimit (| SDU | Lg / MI | , |
| | · William H. | | | | | Inc. Get | tysbu | ırg, | Pa. | |
| | 23. PART i. Enter the disasses, or comp shock, or heart fallure. List | olications that caused the das only one cause on each line. | ith. Do n | ot enter the mo | da of dying, auci | h as cardiac or reap | iratory arres | it, | Approxir interval | Between |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) | Sevile | | Deme | wtiA | | | | Onset ar | nd Death |
| _ | | Sevile OUE TO (OR AS A CONSEON ATHEROS | UENCE OF | FROS | 15 | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A CONSEOR | | | | | | | | |
| ¥Ι | cause. Enter UNDERLYING | | | | | | | | | |
| E | CAUSE (Disease or Injury that initiated events | DUE TO (OR AS A CONSEO | UENCE OF | j: | | | | | | |
| E | resulting in death) LAST | | | | | | | | | |
| CE | d | | | | | | | | | |
| A | | ntributing to death but not re | sulting i | n the undarlying | g cause given in | Part i. 24a. WAS AN PERFO | | | RE AUTOPSY | |
| 2 | PARKINSO | N'S DI | 15 | LASC | | 1 YE8 : | | CC | MPLETION OF | |
| 빌 | , | | | | | | | | DEATH? | I NO |
| 2 | | | | | | | | 1 ' | | , 140 |
| 1 | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PI | ACE OF OEATH (Ch | ack anty one) | | | | |
| 35 | | SPITAL: Inpatient 2 ER/Outpatient 3 | C DOA | OTHER: | | | | | | |
| PHYSICIAN: MEDICAL | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIM | _ | | 8 Other (Specify) 28d. OESCRIBE HOW | INJURY OCCU | BED | | |
| 2 | 1 Netural 8 Pending | (Month, Day, Year) | INJ | URY WO | RK? YES 2 NO | | | 1120 | | |
| B | 2 Accident Investigation | 28e. PLACE OF INJURY — At hor | ne ferm i | | -111 | 28f. LOCATION (Street | and Number of | Dural Bout | Mumbar | |
| E | 3 Suicide 8 Could not be 4 Homicide determined | building, atc. (Specify) | , | Allert, lactory, offic | | City or Town, State | | nural nous | riumoei, | |
| COMPLETED | 204 CERTIFIED | | | | | | | | | |
| 필 | one) | : To the best of my knowledge, dear | | | | | | | | |
| 0 | 2 MEDICAL EXAMINER: On | n the besis of examination and/or in | rvestigatio | n, in my opinion, d | eath occured at the | time, data and place, a | nd due to the | cause(a) an | d manner as | stated. |
| | 206. SIGNATURE AND TITLE OF CERTIFIER | 0 | | | 29c. LICENSE NUI | ABER | 29d. DATE S | SIGNED (M | onth, Day, Yea | 7) |
| BE | Illuhall T s | ulliva M. | 21) | | 7450 | 121 | 1 | PT | 1 | 94 |
| 2 | 30, NAME AND ADDRESS OF PERSON WHO CO | MPLETED CALISE OF DEATH WEN | 27) (Time | Print) | 1179 | -4 | | - / - | 1) | |

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COMPLETED CAUSE OF DEATH OF EM 27) (Type, Print)

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | MENT OF H | | MENTAL HYGIEN | E | |
|--------------------|--|---|--|---------------------|-------------------------|----------------------------|--------------------|--|
| | 1. OECEDENT'S NAME (First, Middle, Lest) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATN |
| 3 | WILLIAM | BA | KER | | | | 22 199 | |
| | 268 20 2950 | № M 2 ☐ F | 81 YRS. | IF UNDER 1 YEAR | HOURS MIN. | 7. DATE OF BIRTH | 1913 | IRTHPLACE (State or Foreign ountry) Ohio |
| OR | 9a. FACILITY NAME (If not institution, give street Prince Georges | | | 9b. CITY, TOWN C | r LOCATION OF DE | АТН | e Georges | |
| ECT | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | 10c CiTY | TOWN OR LOCAT | ON | | | 10d, INSIDE CITY |
| L DIRECTOR | Maryland Anne | Arunde1 | | vidson | ville | LIMITS? | | |
| FUNERAL | 1221 Village I | ake Dr. | | 101 | 201 | 35 | | d States |
| S | | . WAS DECEDENT EVER IN | U.S. ARMED | 13. WAS DEC | | IIC ORIGIN? (Specify Yea | | RACE — American Indian, Black, White, atc. |
| B√ | 1 Never Married 2 Married XX Widowed 4 Divorced | FORCES? 1 YES | 2 T NO | | cify Cuban, Mexica | n, Puerto Rican, atc.) | | aucasian |
| 밑 | 15. DECEDENT'S EDUCATI (Specify only highest grade con | ION npleted) | 18a. DECEDENT'S U | ork done during mo | N at of working | 16b. KIND OF BUS | SINESS/INDUSTR | RY |
| COMPLETED | 12 | College (1-4 or 5+) | Owner | | | Isaly | s Dai | ry Store |
| BE CO | 17. FATNER'S NAME (First, Middle, Last) William | | Baker | | 18. MOTHER'S NA Anna | ME (First, Middle, Maiden | | razel1 |
| 2 | 190.INFORMANT'S NAME (Type/Print) William Baker, J | r. | same | addres | nd Number or Rural F | Route Number, City or Town | n, State, Zip Code |) |
| | 20a, METHOD OF OISPOSITION 1 ABurlel 2 Cremetion 3 Removal 4 Donation 8 Other (Specify) | from State 20b. | PLACE AND DATE OF etery, crematory or other has very been. | er place) Cen | ne of | 0ATE 20c. LO | Carion — city o | eld, Ohio |
| | 21. SIGNATURE OF FIGNERAL SERVICE LICEN | | | | D ADDRESS OF FA | | | |
| | - Clade | 70 | | Ar1 | ington | on Funera , Virgini | la 22 | es 201 |
| | 23. PART I. Enter the diseases, or com- shock, or heart failure. List IMMEDIATE CAUSE (Final disease of condition | t only one cause on as | ich iins. | | | FAILU | | Approximata intsrval Batween Onset and Death |
| | resulting in death) a | DUE TO (OR AS A | CONSEQUENCE OF | - FIE | HICI | TATEO | KE | |
| z | b. | | EMIC | | 10 MY | PHTHY | | |
| ATfo | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | CONSEQUENCE OF) | | | | | |
| FIC | CAUSE (Disease or Injury that initiated events | DUE TO (OR AS A | CONSEQUENCE OF) | : | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | |
| AL 0 | PART II. Other algnificant conditions c | | | | | Part I. 24s. WAS AN | | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO |
| DIC | | DRSTRUCTIV | | | 1321Q 1 | HSC 1 TYES 2 | (J-MO | COMPLETION OF CAUSE OF DEATH? |
| W | | UCAR A | | | | - | | 1 TYES 2 NO |
| IAN | DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL | | F DEATH YES | | UNCERTAIN | ND | | |
| SIC | EXAMINER? | OSPITAL: | - | OTHER: | 5 Residence | 8 Other (Specify) | | |
| Y PHYSICIAN: MEDIC | 27. MANNER OF DEATH 1 Netural 5 Pending | 28a. OATE OF INJURY (Month, Day, Year) | 28b. TIME INJU | OF 28c. INJI | JRY AT | 28d. DESCRIBE HOW II | NJURY OCCURE | 0 |
| TED BY | 3 Suicide 8 Could not be determined | Suicide 8 Could not be 28a. PLACE OF INJURY — At home, ferm, street, factory, office building site. (Specify) | | | | | nd Number or Ru | ral Route Number, |
| COMPLETED | | N: To the best of my knowle | | | | | | |
| | 2 MEDICAL EXAMINER: C | in the dasis of examination | and/or investigation | . In my opinion, di | | | | |
| TO BE | Along c. in | Da. Ju | 2 | | 0 3 9 5 | | DATE SIGN | NEO (Month, Day, Year) -22-9 (|
| | | OMPLETED CAUSE OF DEA | 7 4 S | Tor | bes B1 | vd. Lan | ton . | Md 20706 |
| | 31. DATES EEP Worth Say, 1907) | 32. REGISTRAR'S SIGN | JURE | | | | | |
| | | | | _ | | | | |

70020 10

| | | Page | |
|--|--|--|--|
| BALTIMORE, MARYLAND 21215-0020 | hours after death. Page 6 may be retained by the hospital or attending physician. | ed in by the funeral director, page 5 should be detached for use as the burial-transit permit or removal. | medical examiner must be notified at once. |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760. | TO THE MISSIFIEM ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE THE CONFECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1 - STATE REGISTRAR | SIAIE UF M | CE | | | | DEATH | | WEN IAL HYGIEN REG. NO | - | |
|----------------------|--|---|-----------------------------------|-----------------|--------------------|-------------------------|---|---------|--|--------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Planchard, | -Cy rus | LANCHA | | | | | | 2. DATE OF DEATH DATE OF | | 94 9:10 A M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | B. AGE (In yrs. lest |) | IF UNDER | 1 YEAR DAYS | IF UNDER 24 H | HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | B. BIRTHPLACE (State or Foreign Country) |
| | 031-03-9124 | 1.0 M 2 F | +3 | YRS. | WONTES | DATE | HOUNS | alivi. | 02-24-21 | | MASSACHUSETTS |
| OB | 9e. FACILITY NAME (If not institution, give s UNIVERSITY OF MA | , | | | | | IMORE | OF DE | АТН | 9c. CC | DUNTY OF DEATH |
| ក្អ | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | Y | | 10c CIT | Y, TOWN O | R LOCAT | ION | | | | 10d. INSIDE CITY |
| DIRECTOR | MARYLAND | KENT | | | | ROCK | | | | | LIMITS? |
| FUNERAL | 6928 ROCK HALL R | OAD | | | | 101 | ZIP CODE | 21 | 661 | 10g. C | U.S.A. |
| ВУ | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT FORCES? 1 IF YES, GIVE W | X YES 2 N | | - 1 | f yes, spi | ENDENT OF H scify Cuban, M 2 X NO | dexical | IIC ORIGIN? (Specify Yee n, Puerio Rican, etc.) | or No- | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| ED | 15. DECEDENT'S EDU (Specify only highest grade | | 16e. DE0 | EDENT'S | USUAL OC | CUPATIO | N st of working | | 16b. KIND OF BUS | SINESS/I | NDUSTRY |
| COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5+) 5+ |) life. | Do NOT u | se retired.) YNGOI | | or working | | MEDI | CAL | |
| ő | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | | ME (First, Middle, Maiden | |) |
| BE (| LLOYD HENRY BLAN | CHARD | | | | | FLOR | REN | CE A. SWEE | \mathbf{T} | |
| 5 | 190. INFORMANT'S NAME (Type/Print) ROSE BLANCHARD | (WIFE) | | | | | nd Number or I | | Noute Number, City or Town | | |
| | 20s. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Rem | oval from State | 20b. PLACEA | ND DATE | OF DISPOS | ITION (Na | Tie of | | | | — City or Town, State |
| | 4 Donation 6 Other (Specify) | / 1 | METRO | CRE | | - | | | | NSV. | ILLE, MARYLAND |
| | 21. SIGNATURE OF TUNERAL SERVICE LIC | J. Ke | . 1 | | LI | ROY | | RUS | SELL C WIT | | FUNERAL HOMES NSVILLE MARYLAND |
| CERTIFICATION | 21. PART L Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, approximate interval Batween Consett and Death of the condition resulting in death) Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Approximate interval Batween Onset and Death of the conditions of the conditions of the cause of the ca | | | | | | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other algnificant condition | s contributing to | daath but not re | sulting | in the un | darlying | cause give | n in I | Part I. 24a. WAS AN PERFOR | MED? | Y 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| ME | | | | | | | | | 1 | | 1 TES 2 NO |
| ÿ | DID TOBACCO USE CONT | RIBUTE TO CAL | | | | | UNCER | TAIN | 1 🗆 | | |
| ₫ | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE | OF DEAT | OTHER | | | | | | |
| ΥS | 1 YES 2 NO | 1 Inpetient 2 | | | 4 🗆 Nurs | ing Home | | ence (| 6 Other (Specify) | | |
| ВУ РН | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28e. DATE OF I (Month, Day | INJURY y, Year) | 28b. TIM INJ | E OF URY M | 26c. INJU WOI 1 Y | JRY AT RK? ES 2 NO | | 28d, DEŞCRIBE HOW IF | JURY O | CCURED |
| ا ۵ | 3 Suicide 6 Could not be determined | 26e. PLACE OF building, a | INJURY — At hon itc. (Specify) | ne, farm, s | street, fecto | ory, office | | | 281. LOCATION (Street e City or Town, State) | nd Numb | ber or Runti Route Number, |
| COMPLETE | | | | | | | | | to the cause(e) end man | | tated. the ceuse(e) and manner se stated. |
| TO BE C | 29b. SIGNATURE AND TITLE OF CERTIFIES | hat | | mO. | | | 29c. LICENSE | E NUM | BER | 29d, D/ | ATE SIGNED (Month, Day, Year) |
| F | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE | C MD | 27) (Type, | Print) | IMV | 15 | | | | |
| | 31. DATE FILED (Month, Day, Year) SEP | 0 8 1994 | R MO | wales | Red | 14. | | | | | |

| by the hospital or attending physician. | ir, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should | at once. |
|---|--|--|
| S PRINCARE THE JAW REQUISES that the death certificate be executed within flours after death. Page 6 may be retained by the hospital or attending | conflictions has been signed by the attending physician and completely filled in by the funeral director, page 5 should be stated beat, of Health and Mental Hydiene prior to burial, cremation, or removal. | narked or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OF ATTENTO TO THE FUNERAL DIFFCIT DE filed within, 72 hours and IMPORTANT: IN Item 28

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFIC | ENT OF H | EALTH AND I | MENTAL HYGIEN REG. NO. | | | |
|--------------------|---|---|--|---------------------------|-----------------------------|--|-------------|--------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) Charles Joseph | | | | | 2. DATE OF DEATH MONTH Sept. 5, | 199 | YEAR 3 | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 336-07-7635 90. FACILITY NAME (If not Institution, give si | x⊠ м 2 □ F 1 | 06 YRS. MO | UNDER 1 YEAR OAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Aug. 2, 18 | 888 | Ohio | 0 |
| TOR | Crofton Conv. C | | I | rofto | R LOCATION OF DE | EATH | | ity of DEA | rundel |
| DIRECTOR | | Arundel | | polis | ION | | | | IOd, INSIDE CITY LIMITS? KXYES 2 \(\) NO |
| FUNERAL | 100. STREET AND NUMBER 1135 Little Mag | - | | 2 | 1 4 0 1 | | USA | 4 | AT COUNTRY? |
| ΒX | 1 Never Married 2 Merried 3 X X Idowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 SNO | If yes, spe | | IIC ORIGIN? (Specify Yea n, Puarlo Rican, etc.) | or No- | Black, 1 | - American Indian, White, etc. White |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | | 16a, DECEDENT'S USU (Give kind of work life. Do NOT use rel Watchma | done during mo- ired.) | N at of working | Jewele | | JSTRY | |
| BE COM | 17. FATHER'S NAME (First, Middle, Last) JOhn lawrence | Brislen | | | Mary | ME (First, Middle, Meiden Ellen Ke | Sumame) | | |
| 5 | 190. INFORMANT'S NAME (Type/Print) Irene B. Willet | t | | | | ny View, | | | is, MD |
| | 20e. METHOD OF DISPOSITION 1 Street Burlet 2 Cremetton 3 Remote Burlet 2 Other (Specify) | oval from State | PLACE AND DATE OF DI elery, crematory of other I EEN OI H | eaven | Cemete: | ry Hil | CATION — C | de, | |
| | 21. SIGNATURE OF FUNERAL BERVICE LIC | fardentus | h | 12 Ri | dgly A | neral Honve. Annar | polis | s MD | 21401 |
| | 23. PART I. Entar the diseases, or cahock, or heart failure. I iMMEDIATE CAUSE (Final disease or condition resulting in death) | List only one cause on a | consequence or | tury | da of dying, auci | h as cardlac or reapl | ratory arre | eat, | Approximata interval Between Onaet and Death |
| CERTIFICATION | Sequentially list conditions, If any, laading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| | PART ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PINDINGS | | | | | | | | |
| PHYSICIAN: MEDICAL | PAHI II. Other algoriticant condition | a contributing to death b | ut not resulting in the | e undarlying | cause given in | Part I. 24a. WAS AN PERFOR 1 YES 2 | IMED? | C | VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO |
| AN | DID TOBACCO USE CONTR | | F DEATH YES | | UNCERTAIN | N 🗆 | | | |
| YSIC | EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outp | 01 | HER: | 5 🗆 Residence | 6 Other (Specify) | | | |
| ВУ РН | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY | M 1 Y | IRY AT RK? ES 2 NO | 28d. OESCRIBE HOW IN | JURY OCC | URED | |
| | 3 Suicide 6 Could not be determined | 28a. PLACE OF INJURY building, stc. (Spec | At home, ferm, atree! | t, factory, office | | 261. LOCATION (Street a City or Town, State) | nd Number o | or Rural Rou | ite Number, |
| COMPLETED | onel | CIAN: To the best of my knowl R: On the besis of exemination | | | | | | | and menner se stated. |
| TO BE | 296. SIGNATURE AND TITLE OF CENTIFIER | 1 lava | | | 29c. LICENSE NUM | BER 602 | 29d. DATE | SIGNEO (| Aonth, Bay, Year) |
| | 30. NAME AND ADDRESS OF PERSON SHO | . // | | 0 | | | | 11 | |
| | 31. DATS EP 10"8" 1994 | 722 RESISTRATE SHOP | TURSEL | | | | | | |

HER E

6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL BECORDS DO BOY 68760

| BALTIMORE, MARTLAND ZIZIS-0020 | HYSICIAN: The law requires that the death certificate be executed within inclus after death. Page 6 may be retained by the hospital or attending physician. | is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burta-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | the medical examiner must be notified at once. |
|--|---|---|--|
| Control of the process, F.O. Box 801 60, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within | TO THE FUNETAL CONFIGURA After this certificate has been signed by the attending physician and completely filled in by the ibe ned within 7 years ceath with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal. | IMPORTANT IN 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | | | | | | | 94 | 26311 |
|---------------------------|---|---|------------------------------------|------------------------|-------------------|--|----------------|---|
| | FOR 1 STATE | STATE OF MARYL | AND / DEPAR | TMENT OF | HEALTH AND | MENTAL HYGIEN | ΙE | |
| | REGISTRAR | | | ICATE OF | | REG. NO | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | AY Y | 3. TIME OF DEATH |
| | Elizabeth Marie | Burey | | | | Sept. 4 | , 19 | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (| In yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTN (Month, Day, Year) | 8. | BIRTHPLACE (State or Foreign Country) |
| | 233-12-4753 | 1□ M 2 😾 F 76 | YRS. | MONTHS DAYS | HOURS MIN. | Mar.3,1 | 918 | Virginia |
| | 9a. FACILITY NAME (If not institution, give str | eet and number) | | 9b. CITY, TOWN | OR LOCATION OF D | | | Y OF DEATH |
| O.B. | 1595 Provincial | Lane | | Sever | n | | Anne | Arundel |
| 5 | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY | | | | | | 1 | |
| DIRECTOR | 100.000111 | Arundel | Seve | r, town or loc. ern | ATION | | | 10d. INSIDE CITY LIMITS? 1 YES ZYZYNO |
| FUNERAL | 10a. STREET AND NUMBER | T | | | Of. ZIP CODE | | 10g. CITIZE | N OF WHAT COUNTRY? |
| 111 | 1595 Provincial | Lane | | _ [1 | 21144 | | USA | |
| ا جُ | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN FORCES? 1 YES | U.S. ARMED | 13. WAS DE | CENDENT OF NISPA | NIC ORIGIN? (Specify Ye | e or No- 14 | . RACE — American Indian, |
| BY | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DA | ATES | | S 3/3/NO Speci | en, Puarto Rican, etc.) | | Specify: White |
| | | | | | | | | WIIICE |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade of | ATION completed) | 16a. DECEOENT'S (Give kind of v | rork done during n | | 16b. KIND OF BU | SINESS/INDUS | TRY |
| 3 | Elementary/Secondary (0-12) | College (1-4 or 5+) | Housev | | | ио. | nemake | - × |
| ξ | 12 | | nousev | VIIC | | поі | nemake | =I |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | 1 | AME (First, Middle, Malden | | |
| BE | Wade Hampton Gu | mm | | | | la Judith | | |
| TO BE CON | 19a. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or Tow | | |
| | Becky Wessel | | 1595 | Prov. | incial | Lane, SE | vern, | MD 21144 |
| | 20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Ramo | val from State 20b. | PLACE AND DATE O | F DISPOSITION (A | lame of | | | y or Town, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | M | etery crematory or of Etro C1 | | | | ltimo | re MD |
| CAMILLIAN CAMILLIAN LINES | 21. SIGNATURE OF FUNERAC SERVICE LICE | 11/1// | | | NO ADDRESS OF FA | uneral Ho | omo I | 2 7 |
| CAG | 1 Sals 1 | T/W1 | | | | Ave. Ann | | |
| | 23. PART i. Entar tha diseasea/or of | omplications that caused | tha daath. Do n | ot entar the m | oda of dving, suc | h as cardiac or rean | iratory arrest | LS, MD 21401 |
| | snock, or haart failure? L | ist only one cause on as | ach ilna. | | | | | interval Between |
| | disease or condition | RESPIRA- | TORY | AKRES | 1 | | | Onset and Daath |
| | resulting in death) | | CONSEQUENCE OF | | | | | |
| ' | | · · | 07 | ,- | | | | |
| CERTIFICATION | Sequentially list conditions, | | CONSEQUENCE OF | 3. | | | | |
| ¥ | if any, leading to immediata cause. Enter UNDERLYING | CHREMC | OBSTRU | CTIVE | PULM | MARY | DISEA | 25 |
| Ē | CAUSE (Disease or injury c. that initiated events | | CONSEQUENCE OF | | | | | 0 |
| HTI | resulting in death) LAST | | | | | | | |
| | | | | | | | | |
| ¥. | PART il. Other significant conditions | contributing to death bu | ut not resulting i | n tha underlyir | ng cause givan in | Part I. 24a. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO |
| MEDICAL | | | | | | 1 _ YES 2 | | COMPLETION OF CAUSE OF DEATH? |
| M | | | | | | | | 1 TYES 2 NO |
| ž | DID TOBACCO USE CONTR | IBUTE TO CAUSE OF | F DEATH YE | S I NO [| UNCERTAL | N 🗆 | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 28. PLACE OF OEAT | N (Check only one |) | | | |
| Sign | | HOSPITAL: 1 Inpatient 2 ER/Output | etlent 3 DOA | OTHER: 4 Nursing No. | ne 5 🗆 Residence | 6 Other (Specify) | | |
| F | 27. MANNER OF DEATN | 26a. DATE OF INJURY (Month, Day, Year) | 28b. TIME | OF 26c. IN | JURY AT | 28d. DESCRIBE HOW I | NJURY OCCUP | NED |
| ВУ | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Ibar) | l ma | | ORK? YES 2 NO | | | |
| 0 | 3 Suicide 8 Could not be | 26a. PLACE OF INJURY | — At home, ferm, s | treet, fectory, offi | ce | 28f. LOCATION (Street | and Number or | Rural Route Number, |
| 1 | 4 Nomicide determined | building, etc. (Speci | ny) | | | City or Town, State) | | |
| 44 | 290. CERTIFIER 1 CERTIFYING PHYSIC | IAN: To the best at my knowle | edge death occurre | d at the time .d- | and place and dis | to the enumerical section | | |
| الاحتساء | | | | | | | | ause(s) and manner as stated. |
| - | | | | , | | unio and piece, an | - one to the C | aver(e) and manner as stated. |
| 93 | | <u> </u> | | | | and the same of th | | |
| BE CO | 296. SIGNATURE AND TITLE OF CERTIFIER | walan | | | 29c. LICENSE NU | | 29d. DATE S | GNED (Month, Day, Year) |

30. NAME AND ADDRESS OF PERSON WIPD COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

ALLE MANESWAY MD: 1307 CRATIN

31. DATE FILED (Month, Day May) 0 8 1984 Filed (Month, Day May)

9 | 6 | 9 4 SEP 0 8 1984 Filed Complete Comple

31. OATE FILED (Month, SELP)
9694 SEP

MO 2106/

GLEN SIRME

tend S. E.

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

| | Pages 1, 2 | | |
|--|--|--|--|
| TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within cours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

Item # 1 Film # G 715 09-08-94 N.A Per Funeral Home Item # 17, 18,19a 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 38erkun Maria Surkam 15 Am 7. DATE OF BIRTH 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS th, Day. 17-39-5710 DAYS t [] M 2 [] 80 HOURS YRS 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH LEVINDALE GERIATRIC CENTER DIRECTOR BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE 1 XYES 2 NO OWINGS MILLS FUNERAL 10a, STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 1 RUSH VINE COURT 21117 RUSSIA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Maxican, Puerto Rican, atc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married 2 X NO BY Specify: 3/ Widowed 4 Divorced WHITE COMPLETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16h. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) EDUCATION TEACHER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) BERKUM-LEIB BERKUM 8erkun **ESTHER** 8erkun BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 5 1 RUSH VINE CT, OWINGS MILLS, MD. (21117) ESFIR RAYKMAN Raykhman 20a METHOD OF DISPOSITION
20 Description 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE ARLINGTON CEM. 9/4/94BALTIMORE, MD. ☐ Donation 5 ☐ Other (Specify) . 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS. lau 6010 REISTERSTOWN RD. BALTO.MD. (21215) 23. PART /. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shook, or heert fellure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disesse or condition CARDO RESPIRATORY 138881 resulting in deeth) QUE TO (OR AS A CONSEQUENCE OF) CONGESTIVE HEAVY FORTIC INSYFFICIENCY PAILURE CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If sny, lesding to immediate cause. Enter UNDERLYING ATHEROSCIENCE C TEART DISENSE CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AWILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? PERFORMED? Myelo ily (93 1 TYES 2 TNO 1 | YES 2 | NO 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 YES 2 NO Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER DE DEATH 28a. OATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d. OESCRIBE HOW INJURY OCCURED 5 Pending Investigation 1 Natural М 1 YES 2 NO BY 2 Accident 3 Sulcide 28a. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 Homicide detarmined 29a. CERTIFIER
(Check ank)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE sychur 3 SEP 4481 2

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

A REGISTRAR'S SIGNATURE

INFLEMM. P. NOTHIND

SEP 0 8 1994

31. DATE FILED (Month, Day, Year)

Maloutin and a few

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9c. COUNTY OF DEATH

10g. CITIZEN OF WHAT COUNTRY?

U.S.A.

RACE — American Indian, Black, White, atc.

3. TIME OF DEATH

KENTUCKY

10d. IHSIDE CITY

1 TES 2 1 HO

WHITE

8. BIRTHPLACE (State or Foreign

11:16 PM

REG. NO.

05

2. DATE OF DEATH

7. DATE OF BIRTH (Month, Day, Year)

05-14-42

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| BALTIMORE, MARYLAND 2 | hours after death. Page 6 may be retained by the hospital |
|----------------------------------|---|
| 8 | urs after d |
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| OF VITAL RECORDS, P.O. BOX 68760 | PHYSICIAN: The law requires that the death certificate be executed with |
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FOR STATE REGISTRAR

1. DECEDENT'S HAME (First, Midgle, Last)

4. SOCIAL SECURITY HUMBER

216-38-7331

mardw

9a. FACILITY NAME (If not institution, give atmet and number)

5. SEX

1 M 2 - F

burial-transit permit. Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH ST. AGNES HOSPITAL DIRECTOR BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND BALTIMORE HALETHORPE FUNERAL 10e. STREET AHD NUMBER 101, ZIP CODE 4418 LINDEN AVENUE 21227 or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-It yes, specify Cuban, Maxican, Puerto Rican, atc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 HO IF YES, GIVE WAR OR DATES 1215-0020 1 Hever Married 2 Married ВY 3 Widowed 4 Divorced use as the COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIHD OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done ife. Do NOT use retired.) Por Elamentary/Secondary (0-12) College (1-4 or 5+) 12 MOLDMAKER CARR LOWERY GLASS COMPANY detached notified at once. 17, FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) LEONARD WASHINGTON BOND SR. GARNETTA GEORGE BE 19a. INFORMANT'S HAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 JUDITH E. BOND (WIFE) 4418 LINDEN AVENUE HALETHORPE, MARYLAND Pe 20a. METHOD OF DISPOSITION 20b. PLACE AHD DATE OF DISPOSITION (Name of must 1 St Burlai 2 Cremation 3 Removal from State director, Donation 5 Other (Specify) MEADOWRIDGE CEMETERY 09-09-94 examiner 21. SIGHATURE OF FUNERAL SERVICE LICENSEE 22. NAME AHD ADDRESS OF FACILITY funeral LEROY M & RUSSELL C WITZKE FUNERAL HOMES 1a. the 1630 FOMONDSON AVENUE CATONSVILLE medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, ehock, or heart fellure. List only one cause on each line. in by ŏ filled IMMEDIATE CAUSE (Final cremation, or other traumatic event, the disease or condition completely ACUTE MYDCARDIAL INFARCTION resulting in death) DUE TO (OR AS A CONSEQUENCE OF HRTBALOSCHEROTIC CARPINYAGENLAR and com CERTIFICATION Sequentially list conditions, prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury Hygiene DUE TO (OR AS A CONSEQUENCE OF) thet initiated events attending resulting in death) LAST the atten PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL signed by the any SEVERE ISCHEMIC CARDIO MYO PATHY WITH FAILURE shows Deen of F PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES has be NO D 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h HOSPITAL: OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Realdence 8 Other (Specify) 0 27. MAHNER OF DEATH 28a. DATE OF IHJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY Natural 5 Pending investigation 1 YES 2 NO ВУ 2 Accident 28a. PLACE OF IHJURY — At home, farm, atreet, tactory, office building, atc. (Specify) 3 Suicide COMPLETED 8 Could not be 4 Homicide Mulem 28 29a. CERTIFIER THE CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and manner as stated. (Check only one) FUNEHALL within 72 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, TO THE HOSPITA
TO THE FUNERA
De filed within 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 263

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32. REGISTRAR'S SIGNATURE Sinder

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

HOSP.

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SEP 0 8 1994

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR

DAYS

IF UNDER 24 HRS.

JR.

52

6. AGE (In yrs. last birthday)

21227 20c. LOCATION - City or Town, State DORSEY, MARYLAND Approximeta Interval Between Onset and Death 2 HOURS 20 YRS. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d DATE SIGNED (Month Day Year) MARYLAND 21229 DHMH-18 Rev 1/89

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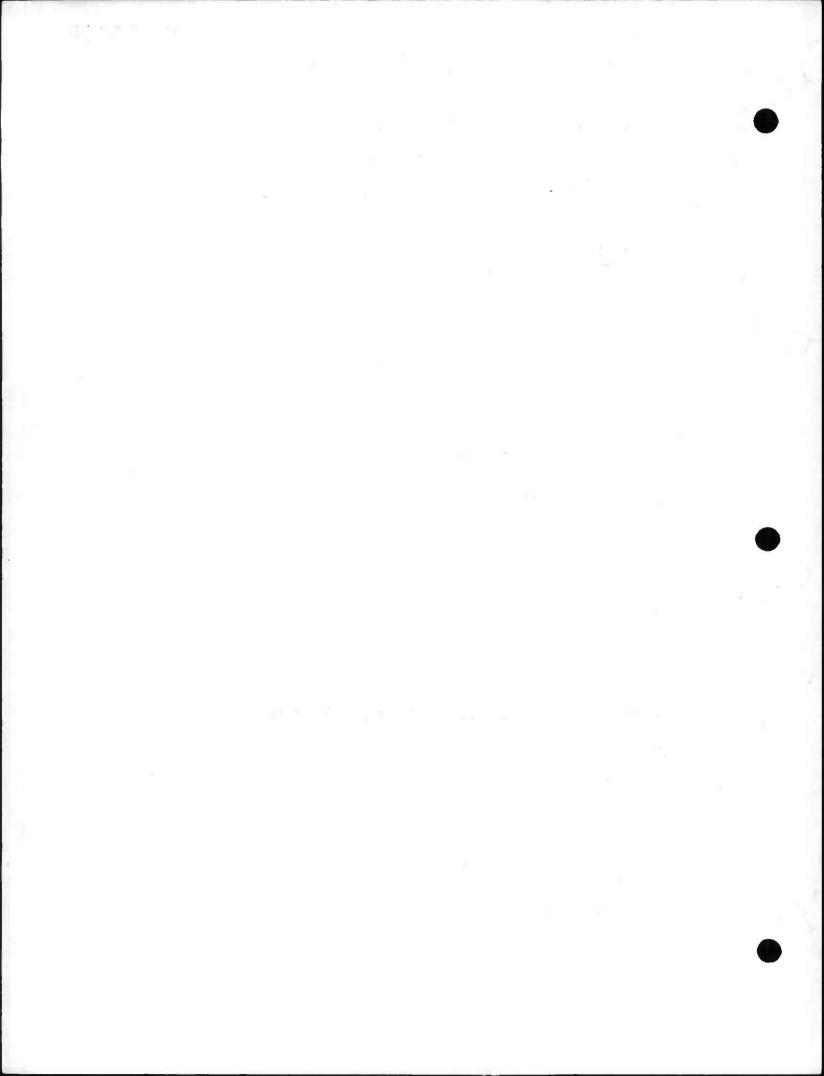
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DIVISION OF VITAL RECORDS, P.O.

| X 68760, BALTIMORE, MARYLAND 21215-0020 | TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within found after death. Page 6 may be retained by the hospital or attending physician. | s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should thin the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | t, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|---|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filled within 72 hours after death with the State Dept, of Heath and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other trau |

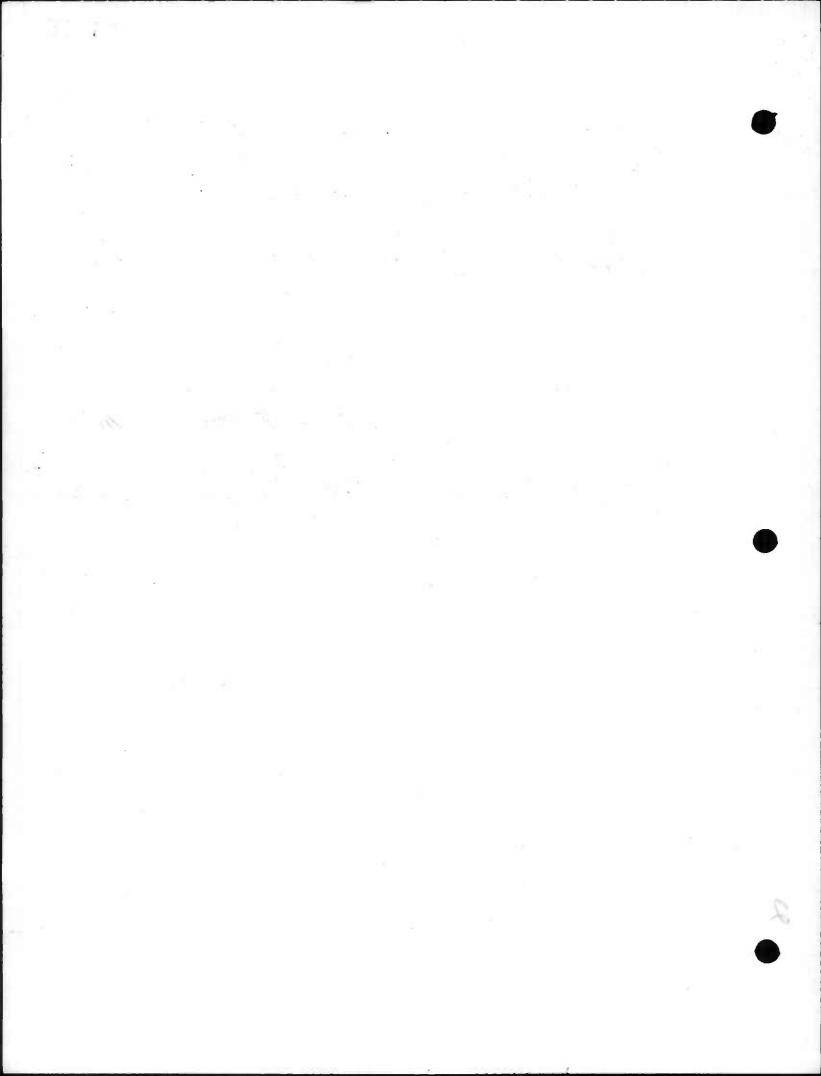
| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAND / DEPART CERTIFIC | MENT OF HEALTH AND MI | ENTAL HYGIENE REG. NO. | |
|---------------|---|---|---|--|---|
| | 1/2/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1 | 15/100 | mmers | DATE OF DEATH 9-5-92 MONTH DAY | 3. TIME OF DEATH |
| | 217 20 02/6 | | FUNDER 1 YEAR IF UNDER 24 HRS. 7 ONTHS DAYS HOURS MIN. | (Month, May, Year) | BIRTHPLACE (State or Foreign Country) I o 11and |
| TOR | 96. FACILITY NAME (If not institution, give street 7 8/ 9 5 + 4 + 6 RESIDENCE OF DECEDENT | ESMAN ST. | Severn | H 9c. COUNTY | OF DEATH |
| DIRECTOR | 10a. STATE 10b. COUNTY | Arundel co | TOWN OR LOCATION Sev | ern | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| FUNERAL | 10a STREET AND NUMBER 7819 Stateman S | Street | 101. ZIP CODE | 10g. CITIZEN | OF WHAT COUNTRY? |
| BY FUNI | | FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC It yes, specify Cuben, Maxican, I YES 2 NO Specify: | ORIGIN? (Specify Yea or No. 14. | RACE - American Indian, Black, White, atc. Specify: White |
| | 15. DECEDENT'S EDUCAT (Specify only highest grade con | mpleted) (Give kind of wor | rk done during most of working | 16b. KIND OF BUSINESS/INDUS | TRY |
| COMPLETED | Elementary/Secondary (0-12) 17. FATHER'S NAME (First, Middle, Last) | College (1-4 or 5+) | Chef | (First, Middle, Maiden Surname) | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | Las varios | | | |
| 5 | 20s. METHOD OF DISPOSITION | | DDRESS (Street and Number or Rural Rou | | |
| | 1 Burlei 2 Cremetion 3 Remove 4 Donetion 5 Other (Specify) 1 1 | state removal | r plece) | DATE 20c. LOCATION — City | |
| | Surged All | Ronald wade, Di | 655W.Baltin | nore St,Balto | * |
| | 23 PART I. Enter the diseases, or comehock, or heart fellure. List | replications that caused the death. Do not tonly one ceuse on each line. | enter the mode of dying, such a | ss cerdiec or respiratory arrest | Approximata Interval Between Onset and Death |
| | disease or condition resulting in death) | DUE TO (OR AS A CONSEQUENCE OF): | | | |
| NOIT | Sequentially liet conditions, if eny, leading to immediate | DUE TO (OR AS A CONSEQUENCE OF): | | | |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Diseese or Injury that initiated evente resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): | | | |
| AL CEF | PART II. Other significent conditions of | contributing to deeth but not resulting in | the underlying cause given in Pa | irt I. 24s. WAS AN AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| MEDICA | | | | PERFORMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| AN: A | 25. WAS CASE REFERRED TO MEDICAL | ENTRIBUTE TO CAUSE OF I | DEATH YES NO | oral con | 1 123 2 RO |
| PHYSICIAN: | 1 See 2 NO | ☐ Inpetfent 2 ☐ ER/Outpetfent 3 ☐ DOA 4 | OTHER: Nursing Home 5 Residence 6 | Other (Specify) | |
| ВУ РН | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME (INJUR | | 6d. DESCRIBE HOW INJURY OCCUR | ED |
| | 3 Suicide 8 Could not be 4 Homicide datermined | 28s. PLACE OF INJURY — At home, term, stre- building, etc. (Specify) | eet, factory, offica | 8t, LOCATION (Street and Number or I City or Town, State) | Burel Route Number, |
| COMPLETED | | N: To the best of my knowledge, death occurred On the basis of examination and/or investigation, | | | suse(s) and manner as stated, |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | Des mo De | 29c. LICENSE NUMBE | | GNED (Month, Day, Year) |
| 5 | 30, NAME AND ADDRESS OF PERSON WHO C | OMPLETED CAUSE OF DEATH (ITEM 27) (Type, Pr | rint) GOS X | merica | 210- |
| | 31. DATE FILED (Month: Day, Year) SEP _ 8 1994 | 32. REGISTRAR'S SIGNATURE | 615/7 | METICA | 21055 |



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| | | 1 - FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HI CERTIFICATE OF | EALTH AND MI | ENTAL HYGIENI REG. NO. | Ē | |
|--|--------------|---|--|---|---|-----------------------------|---|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | CROSS | | DATE OF DEATH | 1994 | 3. TIME OF DEATH |
| - | | 4. SOCIAL SECURITY NUMBER 2/6-16-08/0 | S. SEX S. AGE (In yrs. (and birthday) F UNDER 1 YEAR THE WORTHS DAYS | IF UNDER 24 HRS. THOURS MIN. | Morth, Day, Year) | | THPLACE (State or Foreign |
| 2. 3 should | OR | Church H | one Hosp BALL | LOCATION OF DEAT | City | 9c. COUNTY OF | DEATH |
| ←: | DIRECTOR | 10s. STATE 10b. COUNTY | ISE CITY TOWN ON LOCATE | n n n | | | 10d. INSIDE CITY LIMITS? |
| sit permit. | 4 | 10a STRUCT AND NUMBER | Steent 101. | ZIP CODE | | 10g. CITIZEN OF | 1 YES 2 NO |
| 1215-0020 or attending physician. r use as the burial-transit permit. Pages | BY FUNER | 11. MAPITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | FORCES? 1 YES 2 NO If yee, spe | ENDENT OF HISPANIC cify Cuben, Mexicen, 2 10 Specify: | ORIGIN? (Specify Yee Puerto Rican, etc.) | or No — 14. RA Bis Sp | CE — American Indian, ack, White, etc. |
| MARYLAND 21215-0020 retained by the hospital or attending physic 5 should be detached for use as the burial notified at once. | PLETED | 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) | | N of working | 18b. KIND OF BUS | INESS/INDUSTRY | 3/1/40 |
| YLAND 2 by the hospital be detached for at once. | COMPL | 17. FATHER'S NAME (First, Middle, Last) | , The state of the | 18. MOTHER'S NAME | : (First, Middle, Meiden S | Surneme) | |
| MARYI retained by 5 should be notified at | TO BE | 199, INFORMANT'S NAME (Type/Pgint) | 196. MAILING ADDRESS (Street an | nd Number or Rurai Rou | ite Number City or Town | , State, Zip Code) | En / 21213 |
| TORE, e 6 may be ector, page | | 20e. METHOD OF DISPOSITION 1 Burlet 2 Cremetion 3 Remo | val from State | em, | 97 20c. LOG | ATION — City or | Town State |
| ALTIN leath. Pag funeral did | | III. IIGHATURE OF FUNERAL SERVICE LICE | INSEE 22 NAME AND | O ADDRESS OF WICE | 255 74 | Nerpi | Home |
| urs aft in by remo | | enock, or naem failure. L | omplications that caused the death. Do not enter the modist only one cause on each line. | de of dying, auch | as cardlec or reepir | atory arrest, | Approximata interval Between |
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| P.O. B th certificat ending phy I Hygiene p | ERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): | | | | |
| 25 | N C | | contributing to death but not resulting in the underlying | ceuae given in Pa | ort I. 24s. WAS AN / PERFORI | | 4b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO |
| RECO requires to een signed of Health | MEDIC/ | 10 | roperitoneal mass. | | 1 TYES 2 | No | OMPLETION OF CAUSE OF DEATH? |
| TAL The law ite has t ate Dept em 23 | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSBITAL: OTHER | ACE OF DEATH (Check | | <u> </u> | . 0 |
| OF Persic with the | РНҮ | 27. MANNER OF DEATH 1 Netural 5 Pending | 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WOR | | Other (Specify) 6d. DESCRIBE HOW IN | JURY OCCURED | al. |
| VISION ATTENDING P ECTOR: After In after death in 28 is mar | ETED BY | 2 Accident Investigation 3 Suicide 8 Could not be determined | 28e. PLACE OF INJURY — At home, ferm, atreet, factory, office building, etc. (Specify) | | 81. LOCATION (Street er City or Town, State) | nd Number or Rura | I Route Number, |
| The same | COMPLE | | IAN: To the best of my knowledge, death occurred at the time, date of the basic of exemination end/or investigation, in my opinion, de- | | | | e(e) and manner se stated |
| TO THE HOST IN THE PARTY IN THE | B | 296. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUMBI | | | ED (Month, Day, Year) |
| 2 | 5 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | UMOZ | 1100 11 | 9. | 1 110 01200 |
| | | 31. DATE FILED (Month, Day, Year) SEP 0 8 1994 | 32. REGISTRAR'S SIGNATURE 1 | 7. 70110 | HAP. HO | 50 120 | t mo 21205 |



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| e executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | an and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, | | umatic event, the medical examiner must be notified at once, |
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| equires that the death certificate be execu | cate has been signed by the attending physician and | one prior to | s marked, or item 23 shows any injury, or other traumatic event, the medical examin |
| HOSPITAL OR ATTENDING PHYSICIAN: The law r | FUNERAL DIRECTOR: | ed within 72 hours after death with the State Dept. of Health and Mental Hygli | DRTANT: If item 28 is marked, or item 23 s |
| 2 | THE PE | pe t | IM |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Atticus Alexander MONTH Cooke 4:45 4. SOCIAL SECURITY NUMBER 6. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 218-41-8120 24 May 12,1994 1 X M 2 F Baltimore City 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 3-J Raylon Drive Baltimore Baltimore RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Baltimore Maryland Baltimore 1 YES 2 X NO 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3-J Raylon Drive 21236 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: 11 MARITAL STATUS 14. RACE — American Indian, Black, White, atc. 1XXNever Married 2 Married white 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION

the dane during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A (Infant) N/A 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Justin A. Cooke Megan H. Wallis 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Justin A. Cooke 3-J Raylon Drive Baltimore, Md. 21236 20e. METHOD OF DISPOSITION
1 □ Burlel 2 [X Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 28c. LOCATION -- City or Town, State DATE Metro Crematory Sept.6,1994 Baltimore, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY E. F. LassahnFuneral Home 11750 Belair Road Kingsville, Md. 21087 23. PART i. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sech line. Approximata **IMMEDIATE CAUSE (Final** Onset and Death disease or condition Respiratory Insufficiency
DUE TO (OR AS A CONSEQUENCE OF):

Hypoxic Is hemic Encephalopathy
DUE TO (OR AS A CONSEQUENCE OF): 7 days resulting in death) Sequantially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO OF DEATHS 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🔀 UNCERTAIN 🗆 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 - YES 25 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ng Home 5 - Realdenca 8 - Other (Specify) 27. MANNER OF DEATH 28e, DATE OF INJURY 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED Natural
Accident 5 Pending Investigation 1 YES 2 NO 28a. PLACE OF INJURY — At home, term, street, fectory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be 4 Homicide 29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) end menner as stated. 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. TURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

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WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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Pages 1, 2, 3 should

funeral director, page 5 should be detached for use as the burial-transit permit.

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| X 68760 | executed with | in and completely | to burial, crema | umatic event, |
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| 8, P.O. BO | death certificate be | attending physicia | intal Hygiene prior | ry, or other trau |
| RECORDS | requires that the | been signed by the | t. of Health and Me | shows any inju |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | TO THE HOSPITAL OR ATTORNEYS PASSITAN. The law requires that the death certificate be executed with | antificate has | Travelle State Depr | IMPORTANT. II Item 23 comment, or Item 23 shows any injury, or other traumatic event, |
| DIVISION | AL OR ALTHOUGH | AL DIFFEEDRAM | 72 hours May dear | If Hern 25 and H |
|) | TO THE HOSPI | TO THE FUNER | be filed within | IMPORTANT |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF OEATH RANK 09 615 AM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTN (Month, Day, Year) B. BIRTNPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 118 18 1 M 2 | F YRS. South Carolina 9a. FACILITY NAME (If not institution, give street and nu 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH RESIDENCE OF DECEDENT OF BALTIMORE DIRECTOR BALTIMORE BALTIMORE CITY 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY @Baltimore MD OWINGS MILLS 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? ST RAW HAT 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES TO NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married if yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: Specify: BLACK ВУ 3 Widowed 4 Divorced COMPLETED 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION pecify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver High School 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Sumame) John Cade Minnie Berry BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Alverta S. Cade 2 Strawhat Rd. Owings Mills, Md. 21117 20a. METNOD OF DISPOSITION
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata DATE Carroll Cremation Service9/3/94 4 ☐ Donatton 5 ☐ Other (Specify) Hampstead, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 11824 Reisterstown Rd. lung amo Eline Funeral Home Reisterstown, Md. 21136 As PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory errest, Approximate shock, or heart fallure. List only one cause on each line interval Between Onset and Death IMMEDIATE CAUSE (Finel disesse or condition HYPOSENSION.

DUE TO (OR AS A CONSEQUENCE OF): Ohous resulting in death) SEPSIS CERTIFICATION Sequentisity list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CHOLANG1715 CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initisted events resulting in death) LAST STOMACH CANCER PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? NONE AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO TO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)

EXAMINER? OTHER: 1 TES 2 NO Inpatient 2 ER/Outpatient 3 DOA 27. MANNER OF DEATN

26s. DATE OF INJURY 28b. TIME OF

4 - Nursing Home 5 - Residence 6 - Other (Specify) 25c. INJURY AT WORK? M

>28d. DESCRIBE NOW INJURY OCCURED T YES 2 NO 26a. PLACE OF tNJURY — At home, term, street, factory, office building, stc. (Specify) 2st. LOCATION (Street and Number or Rural Route Number, City or Town, Stata)

29s. CERTIFIER

(Chack only

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

| Keell Robelton | medical motor | 1 |
|--|--------------------|---|
| D. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM | (27) (Type, Print) | / |

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32. REGISTAR'S BIGNATURE

94 Rollinson 31. DATE FILED (Month, Doy, Year) 32. R 32. R 99/02 SEP, 0 8 1994

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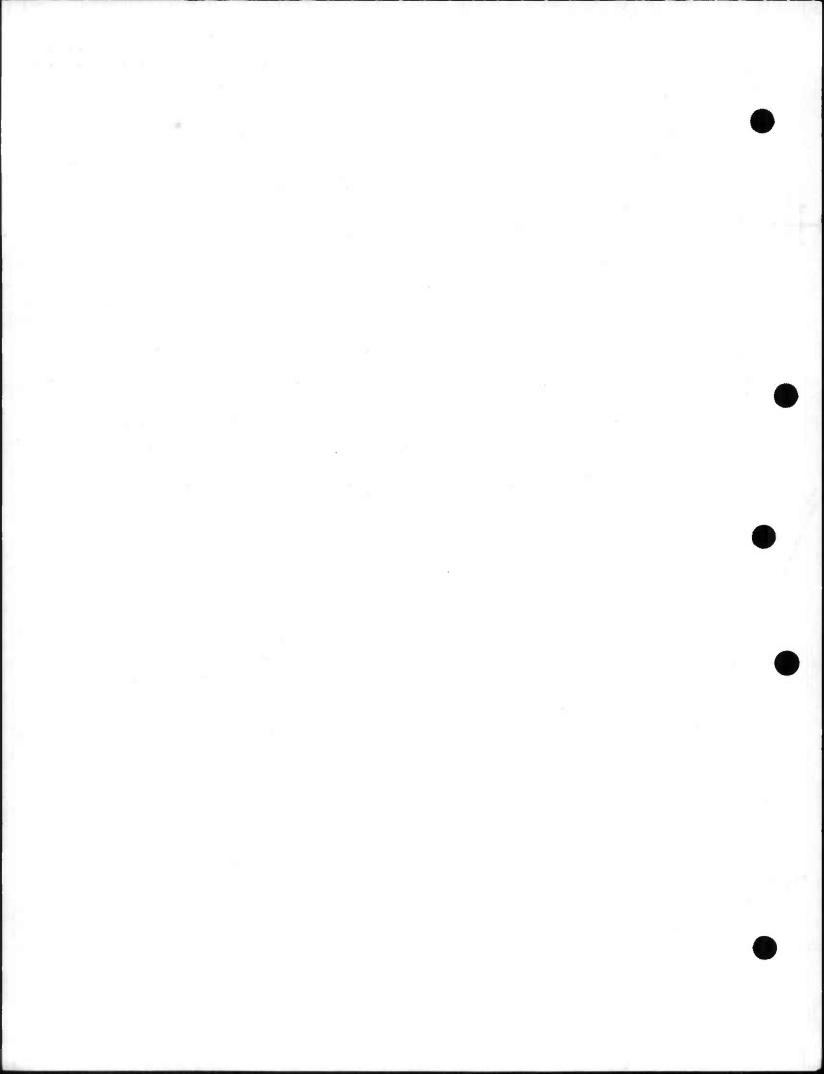
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| BALTIMORE, MARYLAND 21215-0020 | SICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hospital or attending physician. | certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | e medical examiner must be notified at once. |
|---|--|---|--|
| CONTROL OF VITAL RECORDS, P.O. BOX 68760, | TO THE HOSPITAL. A ATTENDING PHYSICIAN: The law requires that the death certificate be executed within | TO THE FUNERAL INTECTION AND THIS Certificate has been signed by the attending physician and completely filled in by the be filed within 72 lower than the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | | MENT OF HEALTH AND CATE OF DEATH | MENT | AL HYGIENE | E | |
|---------------|---|---|--|--|---------------------|---|----------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | , | | | TE OF DEATH | | 3. TIME OF DEATH |
| | 1650 | langel | 081 | | -50 | tember. | 3 1991 | 9:30P M |
| | 4. SOCIAL SECURITY NUMBER | | | UNDER 1 YEAR IF UNDER 24 HRS. | 7. DAT | TE OF BIRTH onth, Day, Year) | 8. 1 | BIRTHPLACE (State or Foreign Country) |
| | 219-40-3452 | | 73 YAS. | | | y 25, 1 | 921 L | ouisiana |
| œ | 90. FACILITY NAME (If not institution, give s Northwest Hospi | | 91 | city, town on location of Randallstown | | | 9c. COUNTY | |
| 5 | RESIDENCE OF DECEDENT | ruc center | | Kanaacestown | | | Balt | imore |
| DIRECTOR | 10e. STATE 10b. COUNT | | 10c. CITY, T | OWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? |
| | Maryland B | Baltimore | | Reisterstown | | | | 1 YES 2 NO |
| FUNERAL | 114 Lamport Ro | ad | | 21136 | | | | OF WHAT COUNTRY? |
| N I | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN | U.S. ARMED | 13. WAS DECENDENT OF HISP | | GIN? (Specify Yea | | RACE — American Indian. |
| BY F | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 YES | | If yes, specify Cuban, Maxi | | o Rican, etc.) | | Black, White, atc. |
| | | | | | | | | s White |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | e completed) | (Give kind of work life. Do NOT use n | done during most of working | | 6b. KIND OF BUS | INESS/INDUST | RY |
| <u> </u> | Elementary/Secondary (0-12) 8 th | College (1-4 or 5+) | Seamsa | | | Clas | thing | |
| Š | 17. FATHER'S NAME (First, Middle, Last) | | | | NAME (Firs | t, Middle, Maiden S | | |
| BE (| Giovan Maria LaS | cuola | | Rosa | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | DRESS (Street and Number or Run | | | | |
| _ | Mary J. Cangelo | | | port Road R | | | | |
| | XX Burlet 2 Cremation 3 Ram 4 Donation 5 Other (Specify) | noval from Stata ceme | tery crematory or other | place) | 1 | Suki | | or Town, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | | ice view in | 22. NAME AND ADDRESS OF | FACILITY | 11601 0 | esucc | e. Mu. |
| | + C Bris | - Proll | | Eline Funeral | Ham | 11824 K | eister | Stown Road |
| | 23. PART i. Enter the diseases, or | complications that caused | the death. Do not | enter tha mode of dying, so | ich as ci | erdiac or respir | ratory arrest, | Approximate |
| Į | ahock, or heart failure. IMMEDIATE CAUSE (Final | List only one cause on as | ch line. | | | | | Interval Between Onset and Death |
| | disease or condition resulting in desth) | · Seps | 115 | | | | | |
| | | DUE TO (ON AS A | CONSEQUENCE OF): | · · \ m | | | | |
| NO N | Sequentially list conditiona, | DUE TO (OR AS A | CONSEQUENCE OF): | MICE | | | | |
| SAT | If any, leading to immadiate cause. Enter UNDERLYING CAUSE (Disease or injury | C. | | | | | | |
| H | that initiated eventa resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | |
| CERTIFICATION | resulting in death) Exst | d | | | | | | |
| AL | PART il. Other algnificant condition | na contributing to death bu | it not resulting in | | in Part i. | 24a. WAS AN A | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| MEDIC | that Sta | of Kelia | Louse | 050 | | 1 TYES 2 | | COMPLETION OF CAUSE OF DEATH? |
| | - HATENOSC | 16 60410 | want o | Justine | | | | 1 TES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | OR BUADE OF DEATH | 0444 | | | |
| SICI | EXAMINER? | HOSPITAL: | | 26. PLACE OF DEATH (THER: Nursing Home 5 Residence | | | | |
| Ή | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 26b. TIME C | F 28c. INJURY AT | _ | EŞCRIBE HOW IN | JURY OCCURE | ED |
| ВУ Б | 1 Natural 5 Pending 2 Accident Investigation | (month, bay, real) | INJUN | WORK? M 1 YES 2 NO | | | | |
| ED E | 3 Suicide 6 Could not be 4 Homicide detarmined | 28a. PLACE OF INJURY building, etc. (Speci | — At home, ferm, stre | et, factory, offica | | OCATION (Street as ity or Town, State) | nd Number or R | Rural Route Number, |
| | 20a CERTIFIER | | | | - | | | |
| COMPLET | (Check only | | | it the time, data and place, and d in my opinion, death occured at ti | | | | |
| | 296. SIGNATURE AND TITLE OF CERTIFIE | | ^ | | | ME and Prece, and | | ./ |
| H | Climbel | frem tree | elve | 29c. LICENSE N | UMBEH | 777 | DATE SIG | QNED (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WE | 10 COMPLETED CAUSE OF DEA | TH (ITEM 27) (Type, Pri | (m) | <i>y</i> – <i>x</i> | 111 | | THE THE |
| | Tuzabith | Mach | Le M | D. North | we | 27 HC | 000 | benter. |
| | \$EP 0 8 1994 | 32. REGISTRAR'S SIGNA | | | | | | |
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| DIVISION OF VITAL | OB ATTERIDIAL DUVELOIA |
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use as the burial-transit permit, Pages 1, 2, 3 should after death. Page 6 may be retained by the hospital or attending physician. by the funeral director, page 5 should be detached for use as the bunial-tran notified at be must examiner removai medical lo by 0 the cremation, event, 1 burial, traumatic and 2 physician Hygiene prior other attending 10 the atten Injury, and Da shows any Signed ! Dept. has Item State certificate the 0 marked, with death 60 DIRECTOR hours after 28 Item TO THE HOSPITAL IN THE FUNERAL DID BE filed within 72 ho

94 26319 Item 19b, Film 715, 9/8/94, 1t STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH **JACOB** CAPLAN 12:40 am 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DAYS 216-01-6314 1 XM 2 - F 79 12-14-1914 MD 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Saint Joseph Hospital Baltimore Towson, Maryland RESIDENCE OF DECEDENT 10e STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE TOWSON 1X YES 2 NO MD 10e. STREET AND NUMBER FUNERAL 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8415 BELLONA LANE, APT.808 21204 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 2 X NO 1 Never Married 2 X Married ВУ 1 YES 2 NO Specify: Specify: WHITE 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade compl Elementary/Secondary (0-12) College (1-4 or 5+) OWNER/OPERATOR MEN'S CLOTHING 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) LOUIS CAPLAN BE ROSE 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Drive Balto Md 2122 AVE APT 808, TOWSON, MD BELLOVA MRS. HELEN CAPLAN 27 204 20a. METHOD OF DISPOSITION
1 X Burlel 2 ☐ Cremation 3 ☐ Ramoval from State 20b. PLACE AND DATE OF OISPOSITION (Name of 20c. LOCATION - City or Town, Stata DATE SHAAREI TFILOH Donation 5 D Other (Specify) 9-4-94 BALTIMORE, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS, INC. 6010 REISTERSTOWN RD, BALTIMORE, MD 21215 23. PART . Part the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Annrovimate interval Between IMMEDIATE CAUSE (Final Onsat and Death disease or condition . ACUTE PULMONARY EDEMA 2DAYS reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART il. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AMILABLE PRIOR TO ISCHEMIC CARDIOMYOPATHY COMPLETION OF CAUSE 1 TYES 2 NO PERIPHERAL VASCULAR DISEASE 1 TES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) BY

| 1 YES 2 ONO | HOSPITAL: 1 Anippetient 2 ER/Outpetient 3 DOA | OTHER: 4 Nursing Home 5 Residence | 6 Other (Specify) |
|---|---|-------------------------------------|---|
| 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | | IME DF NJURY AT WORK? M 1 YES 2 NO | 28d. DEŞCRIBE HOW INJURY OCCURED |
| 3 Suicide 8 Could not be detarmined | 28s. PLACE DF INJURY — At homs, farm building, atc. (Specify) | i, atreat, factory, offica | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
| 29a CERTIFIER | | | |

CENTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as attend.

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2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as elated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

D41410

30. NAME AND ADDRIES OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

JOGINDER P. MEHTA M.D. ST. JOSEPH HOSPITAL TOWSON, MD.

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P. REGISTRAR OSIGNATURE SEP 0 8 1994

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SEE S. 1994 July Phone Rule

FOR STATE REGISTRAR

| | | 1. DECEDENT'S NAME (First VERA | | RRAINE | | CAROTI | ÆRS | | | | 2. DATE OF DEATH MONTH 09 | DAY O | YEAR 94 | 3. TIME OF DEATH | M |
|--|--------------|---|--|--|-----------------------------------|--------------------------------------|---|----------------|---------------|------------|--|---------------|------------|--|----|
| | | 4. SOCIAL SECURITY NUMBER 216-01-9895 | | 5. SEX | 6. AGE (In yrs | last birthday) YRS. | IF UNDER | 1 YEAR DAYS | IF UNDER | 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) 05-24- | 72 | 8. BIRTH | PLACE (State or Foreign | _ |
| 2, 3 should | OR | 9a. FACILITY NAME (If not in 303 MAIDEN | estitution, give s | | APT. | | 9b. CITY | | | ON OF DEA | ATH | 9c. COUR | NTY OF DE | | _ |
| - | DIRECTOR | PRESIDENCE OF DEC | 10b. COUNT | , BALTIMORE | 3 | 10c. Ci | ry, town (| | | /ILLF | | - | | 10d. INSIDE CITY LIMITS? 1 YES 2/3/NO | _ |
| physician. burial-transit permit, Pages | FUNERAL | 100. STREET AND NUMBER 303 MAIDEN | | LANE | APT. | 305 | | 101 | I. ZIP COD | E 21228 | } | | ZEN OF W | HAT COUNTRY? | |
| the the | ВУ | 11. MARITAL STATUS 11. Never Married 2 3 Widowed 4 Dive | | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | YES 2 | ARMED NO | | If yes, sp | | n, Maxican | C ORIGIN? (Specify), Puarte Rican, etc.) | fea or No | | — American Indian, t, White, etc. | |
| 0 TO | 1111 | (Specify on | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | | | S USUAL O work done ise retired.) | during mo | ost of workir | _ | TOWSON | | 2 | | |
| by the hospital d be detached fo d at once. | | 17. FATHER'S NAME (First, A | ROTHER | RS | ,,,,,, | | | | 18. MOT | | MORRIS | | | | |
| s shoul | TO B | 198. INFORMANT'S NAME (RUTH M. CUM | | (COUSIN | 1) | 196. MAILIN | | | | | oute Number, City or R SALTIMORE | | | 21228 | |
| 60 E | | 20a. METHOD OF DISPOSIT 1 Burlal 2 Crematic 4 Donation 5 Other | (Specify) | | cemetery | ce and date cremetory or ON PA | RK CF | UKEIVO | ERY (| | 3-94 BA | LOCATION — | | wn, State ARYLAND | |
| 0 = 0 | | 21. SIGNATURE OF PURERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY LEROY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | | | |) |
| etely filled in by the emation, or removal. | | | eart fellure. | List only one cer | MC (A | line. | not enter | the mo | ede of dy | ing, auch | as cardiac or rea | epiratory arr | reat, | Approximate interval Betwee Onset and Dear | en |
| ficate be executed with the physician and completely fille ne prior to burial, cremation, ner traumatic event, the | ERTIFICATION | Sequentially list conditions, leading to imme cause. Enter UNDERLY | diete | · Arter | OR AS A COM | ofic | Car | dio | vas | ula | n diseo | se | | | |
| th certifica ending ph Il Hygiene or other | ERTIFI | CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| uires that the d signed by the Health and Me | MEDICAL C | PART II. Other significa | ot resulting | In the u | nderlyin | g cause | given in i | PERF | PERFORMED? | | WERE AUTOPSY FINDING: AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | |
| | SICIAN: | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO State REFERRED TO MEDICAL EXAMINER? 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: OTHER: | | | | | | | | | | | | | _ |
| PHY this with | Y PHYS | | Pending Investigation | 28s. DATE Of (Month, I | FINJURY | 28b. TI | 4 🗆 Nus | 28c. IN. | JURY AT ORK? | | B Other (Specify) 28d. DESCRIBE HOV | V INJURY OC | CURED | | _ |
| R ATTENDING RECTOR: After ura after death um 28 is ma | TED BY | 2 Accident 3 Suicide a 4 Homicide | Could not be determined | | OF INJURY — A , etc. (Specify) | it home, term, | street, fac | tory, offic | ca . | | 281. LOCATION (Stree City or Town, Sta | | or Rural R | loute Number, | _ |
| OSATAL DR. Min 72 oue | COMPLE | anal | | | | | | | | | to the cause(a) and n | | | e) and manner as stated. | |
| H P P P P P P P P P P P P P P P P P P P | TO BE (| 7. C. LUTTEN | 1 03 | onovan | M. | b . | 81.0 | | apc. LIC | 763 | BER | 29d. DAT | E SIGNED | (Month, Day, Year) | |
| | | J. C. ROSSIMO | 01 | MAYONE | , 21 | UZ D | o Print) | AL. | K | AVE | ., BA | 20 | MD | 21222 | |
| | | SEP 0 8 195 | 14 | 7 | AÁ'S SIGNATUR | | | | | | | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

Chronic inclamic myocardish dis Astriwalerofic conductoraular

m, M.D.

31. DATE FILEO (Month, Day, Year)
SEP 0 8 1994

32. REPUSTRATE SIGNITURE

| | | 1 - STATE REGISTRAR | STATE OF MA | | | | OF DEAL | | | G. NO. | | |
|--|----------|--|---|-------------------------------|----------------|--------------------------------|--|---------------|--------------------------------|----------------------------|----------------------|---|
| | 1 | 1. OECEDENT'S NAME (First, Middle, Last) | Helen H | latch | Cawl | ey | | | 2. DATE OF DE | | VEAD | 3. TIME OF DEATH |
| | | Helen HHI | c.h | Cu | wle | | | Se | Ren Ge A | L 3 | YEAR | 6:30 PM |
| | - 1 | 4. SOCIAL SECURITY NUMBER | | B. AGE (In yrs. I | Y | IF UNDER 1 YE | | MIN | 7. DATE OF BII (Month, Day, | Year) | 8. BIRTHI Country | PLACE (State or Foreign |
| pin | | 262-72-7613 9e. FACILITY NAME (If not institution, give : | 1 □ M 2/√√ F | 94 | YRS. | 100 | | | 2-4-19 | 00 | Nort | h Carolina |
| 3 should | œ | | <i>'</i> | | | | WN OR LOCAT | ION OF OEA | TH | | UNTY OF OE | |
| 1, 2, | 2 | Magnolia Gardens | Nursing H | lome | | Lanh | am | | | Pr | ince | George |
| ages | DIRECTOR | 10e. STATE 10b. COUNT | | | 127 | TOWN OR LO | | | | | T | 10d. INSIDE CITY LIMITS? |
| burlal-transit permit. Pages | L DI | Maryland Princ | ce George | | Co | llege | | | | | | 1 YES 2 X NO |
| it per | RA | 0 = 0 10 = = 00 = 0 = 0 = 0 | | | | | 101. ZIP COD | | | | | HAT COUNTRY? |
| -trans | FUNERA | 6811 Dartmouth Av | 12. WAS DECEDENT | EVER IN U.S. A | RMED | 12 WAS | 20740 | | OBICINA PR | cify Yea or No- | SA | A |
| burla | | 1 Never Married 2 Married | FORCES? 1 | YES 2 | NO | If yes | | ın, Maxican, | Puarto Rican, | | Bleck, | — American Indian, White, atc. |
| as the | BY | 3 Wildowed 4 Divorced | | 77.7 | | 1 | 125 2 10 | эрвену. | | | Specify | white |
| nse | ETED | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | (| Give kind of w | DSUAL OCCUP ork done during | ATION most of world | ng | 16b. KIND | OF BUSINESS/II | NDUSTRY | |
| ĮQ. | | Elementary/Secondary (0-12) | College (1-4 or 5+) | | omemak | | | | п | ome | | |
| detached once. | COMP | 17. FATHER'S NAME (First, Middle, Last) | 0 | 110 | шешак | <u>e1</u> | 18 MOT | HER'S NAM | | Maiden Surname) | | |
| p d | ш | Buckner Hill Ha | ch | | | | | | Bethea | maden dementey | | |
| 5 should notified | 0 B | 19s, INFORMANT'S NAME (Type/Print) | | 1 | 9b. MAILING | ADDRESS (Str | eet and Numbe | r or Rural Ro | ute Number, City | or Town, State, 2 | (ip Code) | |
| page 5 should be t be notified at | F | Jack Barnes | | | 6811 | Dartmo | outh A | venue | Col1 | ege Par | k, MD | 20740 |
| ector, pa | • | 20a. METHOO OF DISPOSITION 1 Burlet 2XXCremation 3 Rem | oval from Stata | 20b. PLACE cometery, c | AND DATE O | F DISPOSITION | N(Name of a grant of a | 0 | OATE | 20c. LOCATION - | | |
| direc | | 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE-LIN | ENGEE A | Balti | more | | e AND ADDRE | | | Laurel | , Mar | yland |
| tuneral di examiner | 4 | 1/1/1/ | 104/ | 2-1 | | | | | Home, | Inc. | | |
| the frowal. | | 22 DADT I February the discourse or | XXIL | cerk | aj | 7601 | Sand | y Spr | ing Ro | ad Lau | rel, | MD 20707 |
| or remove medical | | 23. PART Enter the diseases, or shock, or heart fellure. | List only one cause | e on each lic | eath. Do n | ot enter the | mode of dy | ing, such | as cerdiac o | r respiratory a | rrest, | Approximate interval Between |
| y filler the | | iMMEDIATE CAUSE (Final disease or condition | Cere | bor | 1 | Xa A | ceid | 5-4 | - | | | Onset and Death |
| ompletely fille if, cremation, event, the | | resulting in desth) | | OR AS A CONS | EQUENCE OF | | , | 7 7 | | | | Fero Min |
| | NO | | . Atri | al | Fib | ri//a, | fron | | | | | > 1 yr. |
| sician and c irlor to buria traumatic | ST. | Sequentially list conditiona, if any, leading to immediate | DUE TO (O | R AS A CONSI | EQUENCE OF |): | | | | | | |
| physic ne pric | FICATI | cause. Enter UNDERLYING CAUSE (Disease or Injury | C. DUE TO (O | R AS A CONSI | FOLIENCE OF | Le . | | | | | | |
| Hygiene por other | RTIFI | that initieted events resulting in deeth) LAST | DOE 10 (0 | A A CONSI | EUDENCE OF |)[| | | | | | |
| y the atter of Mental injury, o | 8 | DATE IS ONLY IN THE REAL PROPERTY. | d | | | | | | | | | 1 |
| 200 | CAL | PART II. Other algnificant condition | | 1. | | | | given in Po | ort i. 24a. | PERFORMED? | 7.75 | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| lealth ws an | MEDI | Vascula, | Demen | | | -12h | P-41 | | _ 10 | YES 2 THO | | COMPLETION OF CAUSE OF DEATH? |
| been sign t. of Heat shows | | - 250(4) | 2154 | 45C. | | | | | - | | | 1 NES 2-NO |
| e Depr | SICIAN | 25. WAS CASE REFERRED TO MEDICAL | | | | 26 | S. PLACE OF O | EATH (Check | (only one) | | | |
| e Stat | Sic | EXAMINER? | HOSPITAL: | ER/Outpatient | | OTHER: | Home 5 🗆 Ri | asidence 6 | Other (Spec | ffy) | | |
| ith the | PHY | 27. MANNER OF DEATH | 28a. DATE OF th (Month, Day, | | 28b. TIME | OF 28c. | INJURY AT WORK? | | | HOW INJURY OF | CCURED | |
| ter th ath w | BY | 1 Natural 5 Pending 2 Accident Investigation | | | | M 1 | YES 2 | NO | | | | |
| OR: A | G | 3 Suicide 8 Could not be 4 Homicide determined | 28a. PLACE OF building, at | INJURY — At h c. (Specify) | ome, larm, st | reel, factory, o | offica | 2 | BI. LOCATION City or Town | (Street and Number, State) | er or Rural Ro | oute Number, |
| IRECTIONES AT 2 | | | 2 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | - | | | | | | | |
| ZAL D | COMPLET | (Check only | | | | | | | | | | |
| FUNE within | 8 | 2 MEOICAL EXAMINE | | mination and/or | investigation | , in my opinio | | | | | | |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed be filed within 72 hours after death with the State Dept. of Health iMPORTANT: If Item 28 is marked, or Item 23 shows an | H | 296. BIOGRATURE AND TITLE OF CERTIFIES | | CONO | rino | MAN | 29c. LICI | ENSE NUMB | ER | 29d. DA | TE SIGNED | Mofth, Day, Year) |
| 2 % ₹ | 2 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETEO CAUSE | OF DEATH (IT) | EM 271/1/200 | Print) | | V 31 C | - 0(| | 7/4 | 77 |
| | . 11 | The second secon | | | | | | | | | | |

| 1 | - | FOR STATE REGISTR | AR |
|---|------|-------------------------|-----|
| i | 1. D | ECEDENT'S | NAI |
| ï | 1 | Roger | R |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| i | 1. DECEDENT'S NAME (First, Middle, Last) | , | | | | | | | 2. DATE OF | DEATH | | | 3. TIME OF DEATH |
|---------------|--|---------------------------|--|--|------------------|---------------------|----------------------|---------------------|----------------------------|---------------------------|------------|--------------|--|
| 1 | Roger Ray Carpe | nter | | | | | | | Augusa | t 29, | 199 | 4 YEAR | 8:32 A. M |
| 1 | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. las | st birthday) | | R 1 YEAR | IF UNDER | _ | 7. DATE OF E | BIRTH | | S. BIRTH | IPI ACE (State or Foreign |
| Man of | 225-46-3361 | 1XX M 2 □ F | 56 | YRS. | MONTHS | DAYS | HOURS | MIN. | Augus? | £ 24, | 138 | Vi | rginia |
| œ | 90. FACILITY NAME (If not institution, give 3387 Old Line A) | | | | 9b. CITY | | OR LOCATIO | ON OF DE | HTA | | | NTY OF D | |
| DIRECTOR | RESIDENCE OF DECEDENT | renue | | | | Law | iec | | | | Ari | ine r | rundel |
| REC | 10a. STATE 10b. COUNT | | | 10c, CIT | ry, TOWN | | | | | | | | 10d. INSIDE CITY LIMITS? |
| | Maryland A | nne Aruna | lel | | | Law | | | | | | | 1 TES 2 NO |
| FUNERAL | 3387 Old Line Av | 11010110 | | | | 101 | 2072 | _ | | | | IZEN OF V | WHAT COUNTRY? |
| NS I | 11. MARITAL STATUS | 12. WAS DECEDE | ENT EVER IN U.S. AR | AMED | 13. | WAS DEC | | | NC ORIGIN? (S | necify Yee | | 14. BAC | E — American Indian, |
| BY | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE | 1 ☐ YES 2 ☐ N WAR OR DATES | NO | - 8 | It yes, sp | ecify Cuba 2 X NO | n, Mexica | n, Puarto Ricar | n, atc.) | | Blac | k, white white |
| TEC | 15. DECEDENT'S EDI (Specify only highest grad | | 16a. DE | ECEDENT'S Give kind of a Do NOT us | USUAL O | during mo | ON ost of working | ng | 16b. KIN | ID OF BUS | SINESS/INC | DUSTRY | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5 | | set | | | | | PA | inti | ing | | |
| Š | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 16. MOTI | HER'S NA | ME (First, Middl | le. Maiden | | _ | |
| BE C | Smith Carpenter | | | | | | | | en Harl | | | | |
| 10 | 19a. INFORMANT'S NAME (Typo/Print) Barbara M. Carpe | enter | 198 | b. MAILING 3387 | old | s (Street a Line | and Number 2 Ave | or Rural F .NUC, | Ploute Number, (Lawre | el, N | 1D | 2072 | · |
| | 20a. METHOD OF DISPOSITION 1 XBurial 2 Cremation 3 Ren 4 Donation 5 Other (Specify) | | 20b. PLACE A cometery, cred Mt. Co | | other place) | emter | LU | | 8/31 | Ale | cation – | lria. | Virginia |
| | 21. SIGNATURE OF FUNERAL SERVICE L | CEMBER O | bado | | 22. | . NAME A | ND ADDRES | ss of fa | CILITY F | 2eck | Fune | ral | Home, Inc. MD 20707 |
| | 23. PART /. Enter the diseases, or | complications th | at sauged the de | utti. Do i | | | | | _ | | | | Approximate |
| | IMMEDIATE CAUSE (Final | List entry one ca | nee, ou each-ribe | 1 | 5 | | | | | | | | Interval Batween Onset and Death |
| | disease or condition resulting in death) | Tav | creat | tic | 4 | erc | ino | mo | ~ | | | | |
| | | TUE TO | O (OR AS A CONSEC | OUENCE O | (F): | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | b. DUE TO | O (OR AS A CONSEC | OUENCE O | F): | | | | | | | | |
| S | cause. Entar UNDERLYING CAUSE (Disease or Injury | с | | | | | | | | | | | |
| F | that initiated events resulting in death) LAST | DUE TO | O (OR AS A CONSEC | OUENCE O | F): | | | | | | | | |
| SE I | | d | | | | | | | | | | | |
| | PART II. Other significant condition | ns contributing to | o death but not r | resulting | in the u | nderlyln | g cause (| given in | Part I. 24 | . WAS AN | | 24b | . WERE AUTOPSY FINDINGS AMILABLE PRIOR TO |
| EDICAL | | | | | | | | | 1 [| YES 2 | □ NO | | CDMPLETION OF CAUSE OF DEATH? |
| Σ | DID TOBACCO USE | CONTRIBIL | TE TO CAL | ISE O | E DE | A TIJ | VEC T | 7 1/2 | ~ [| | | | 1 TYES 2 NO |
| AN | 25. WAS CASE REFERRED TO MEDICAL | T | IE IO CAU | Jae C | ר טני | | YES [| EATH (Ch | eck only one) | | | | |
| PHYSICIAN | EXAMINER? 1 YES 2 NO | HOSPITAL: | ☐ ER/Outpatient 3 | DOA | OTHE 4 Nui | R: | / | | 6 Other (Sp | pecify) | | | |
| PHY | 27. MANNER OF DEATH | 28a. DATE Of (Month, I | OF INJURY Day, Year) | 28b. TIM | _ | 28c. INJ | | | 28d. DESCRI | | NJURY OC | CURED | |
| BY | 1 Matural 5 Pending 2 Accident Investigation | | | | М | 1 🗆 1 | YES 2 | NO | | | | | |
| | 3 Suicide 8 Could not be 4 Homicide detarmined | | OF INJURY — At ho g, atc. (Specify) | yme, term, | street, tac | tory, offic | • | | 28t. LOCATIO City or To | N (Street a wn, State) | and Number | r or Rural i | Poute Number, |
| COMPLETED | one) | SICIAN: To the best o | | | | | | | | | | | a) and manner as stated. |
| шН | SA SHOULTUNE AND TITLE OF CENTIFIE | EM C | | | | | 29c LICI | ENSE NUN | MBER | | 29d. DAT | E SIGNED | (Month, Day, Year) |
| TO B | July M | ND | | | | | 0 | 24 | 942 | | 19 | 8-2 | 9-94 |
| | 30. NAME AND ADDRESS OF PERSON W | HO COMPOSTED CAL | AUN ITE | M27 (700 | Print) | 331 | 70 | her | ny La | no | Lay | rel | MD24707 |
| | SFP 0 8 1994 | 132 REGISTA | AR'S SIGNAFORE | alle | | | 1 | | , | | | | 7 |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 6 may be retained by the hospital or attending physician and completely filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
|---|---------|
| CERTIFICATE OF DEATH | BEG NO |

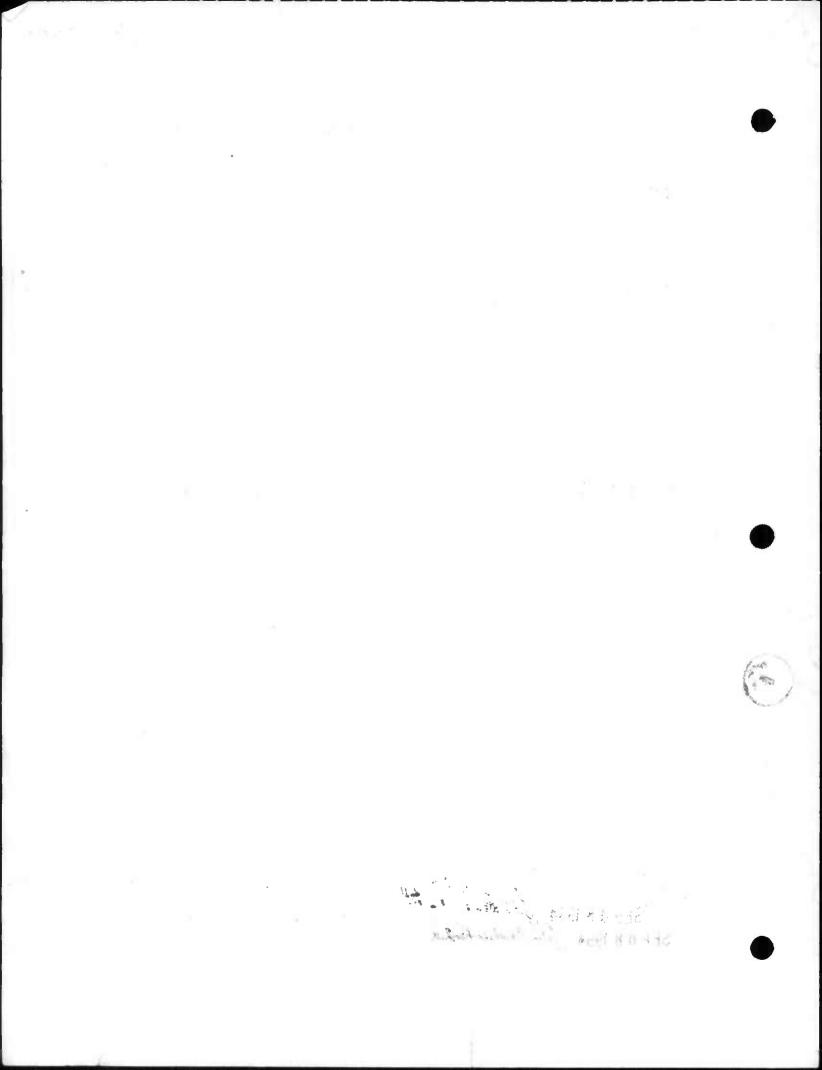
| | 1 - STATE STATE REGISTRAR | E OF MARYLAND / | DEPARTMENT OF ERTIFICATE O | HEALTH AND N | MENTAL HYGIEN | | |
|---------------|---|--|---|--|--|-----------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | Reba D | unie | | 2. DATE OF OEATH MONTH | WY 1 | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | 6. AGE (In yrs. les | | IF UNDER 24 HRS. | 5EP C | - | BIRTHPLACE (State of Foreign |
| | 216-01-1827 10M | 40.44 | YRS. MONTHS DAYS | HOURS MIN. | (Month, Day, Year) | | Country) NORTH CAROLINA |
| | 9a. FACILITY NAME (If not institution, give street and nu | mber) | 9b. CITY, TOWI | OR LOCATION OF DE | APR 30, | + | Y OF DEATH |
| DIRECTOR | Si con of bo | ltimore | 1000 | more | | | (income) |
| l m | 10a. STATE 10b. COUNTY MARYLAND | | 10c. CITY, TOWN OR LOC | ATION | | | 10d. INSIDE CITY |
| 1 1 | MARIGAND | | BALTI | 10RE | | | LIMITS? |
| FUNERAL | 3623 GLENGYLE AVE. | | | 01. ZIP CODE 21215 | | 10g. CITIZE | N OF WHAT COUNTRY? USA |
| 5 | | DECEDENT EVER IN U.S. AR | | CENDENT OF HISPAN | IIC ORIGIN? (Specify Ye | s or No — 14 | I. RACE — American Indian, |
| | IF YE | ES? 1 TYES 2 X S, GIVE WAR OR DATES | | pecify Cuban, Maxican S 2 XNO Specify | | | Black, White, atc. |
| BY | 3 Widowed 4 Divorced | | | | | | WHITE |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | (G | CEOENT'S USUAL OCCUPA ive kind of work done during | ION lost of working | 18b. KIND OF BU | SINESS/INDUS | STRY |
| l E | Elementary/Secondary (0-12) College | (1-4 or 5 +) | Do NOT use retired.) | 7 | GT OFFI | | |
| N N | 17. FATHER'S NAME (First, Middle, Lest) | | SALESPERSO | · | CLOTH | | |
| | HARRIS | DUN | TE | | ME (First, Middle, Maiden | , | |
| 8 | 19a. INFORMANT'S NAME (Type/Print) | | | MAUD | | LEVIN | |
| 유 | MRS. ANN FLAX | | 3623 GLENGY | | | | , |
| | 20a. METHOD OF DISPOSITION | T T | | | | | |
| | 1 X Buriel 2 Cremation 3 Removal from | State cemetery or | INDIDATE OF DISPOSITION (| RF. C | | LTIMOR | y or Town, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 1 0 | | | | | CL/ FID |
| | Sylvey L Stal | lua | | | N & BROS., RSTOWN RD. | | MORE, MD 21215 |
| | 23. PART I. Entar the diseases, or complicet shock, or heart fallure. List only | ons that caused tha de | ath. Do not enter the n | ode of dying, such | as cardlec or resp | iratory arres | |
| | IMMEDIATE CAUSE (Final | | | | | | intarval Between Onset and Death |
| | disease or condition resulting in death) | Met | Dehndra | tion | | | |
| | | DUE TO (OR AS A CONSEC | DUENCE OF): | 2 00 | | | |
| Z | Sequentielly list conditions, 6. | DUE TO (OR AS A CONSECUTION OF TO (OR AS A CONSE | Bladder | Cell C | A (Tra | nsifi | onall Iyv. |
| CERTIFICATION | If any, leeding to immediate cause. Enter UNDERLYING | DUE TO (OR AS A CONSEC | DUENCE OF): | | | | |
| 일 | CAUSE (Disease or injury C. | OUE TO (OR AS A CONSEC | VIENCE OF | | | | |
| I ∰ I | that initiated events resulting in death) LAST | TO ON AS A CONSEC | JOENCE OF). | | | | |
| E | d | | | | | | |
| A P | PART II. Other significant conditions contrib | uting to death but not r | eaulting in the underly | ng ceuse given in | 0.000.00 | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| | | | | | 1 YES : | | COMPLETION OF CAUSE OF DEATH? |
| MEDICA | | | | | | | 1 TYES 2 NO |
| ż | DID TOBACCO USE CONTR | IBUTE TO CAUS | SE OF DEATH | YES NO | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | TAL | | PLACE OF DEATH (Che | ack only one) | | |
| \SI | | lient 2 ER/Outpetient 3 | □ DOA 4 □ Nursing He | me 5 🗆 Rasidence | 8 Other (Specify) | | |
| 표 | | DATE OF INJURY (Month, Day, Year) | 28b. TIME OF 28c. I | JURY AT | 28d. DESCRIBE HOW | INJURY OCCUP | RED |
| B | 1 X Natural 5 Pending 2 Accident Investigation | *************************************** | M 1 | YES 2 NO | | | |
| | o Codid not be | PLACE OF INJURY — At he building, etc. (Specify) | me, ferm, atreet, fectory, of | ce | 281. LOCATION (Street City or Town, State | and Number or | Rural Route Number, |
| | 4 Homicide determined | | | | | | |
| COMPLETED | 299. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the | | | | | | |
| Š | one) 2 MEOICAL EXAMINER: On the t | pasis of examination and/or I | nveatigation, in my opinion | death occured at the | time, data and place, er | nd due to the o | cause(e) end mannar as stated. |
| BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | 29c. LICENSE NUM | BER RC 9803 | 29d. DATE S | SIGNED (Month, Day, Year) |
| TO B | R. Crook. Do. | Intern | | AS 240 | 2321 | 104 | ISEP 94 |
| F | 30. NAME AND ADDRESS OF PERSON WHO COMPLE | | | 0 00 | | | |
| | R. Crock, Do, | Intern - | Sinai o | + Baltin | noce. | Bult | imore, MD |
| | 31. DATE FILED (Month, Day, Year) 32. F | | | | | | |
| | SEP 0 8 1994 Julia 2016 | volen-hardally | | | | | |

1394 - Land 1394

8

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-715 9/15/94 t.t

| 1 12 | 1. DECEDENT'S NAME (First, A | MIGGIE, LIIST) | | | | | | | | 2. DATE | OF DEATH | | | 3. TIME OF DEATH |
|------------------------------------|--|--|--|--|--|---|---|--|--|--|---|--|---|--|
| 1 1 | DWAYNE | | Α. | | | Г | OWN | īS | | MONT | H D | | YEAR | |
| - 8 | 4. SOCIAL SECURITY NUMBE | R | 5. SEX | 6. AGE (I | n yrs. last birthday) | IF UNDER | | IF UNDER | 24 MBC | | OF BIRTH | $\frac{1}{1}$ | | 994 1:06 HPLACE (State or Fore |
| - 1 | 218-98-684 | | 1)∑M 2 □ F | 2.3 | | MONTHS | DAYS | HOURS | MIN. | (Mon | th, Day, Year) | | Coun | (ny) |
| | 9a. FACILITY NAME (If not inst | | | 43 |) | an CITY | TOWN C | OR LOCATIO | 201 05 05 | | 10-/1 | | | LTO. MD |
| œ | | | | מק | | (2) | | MOR | | ATH | | 9c. COUN | ITY OF I | DEATH |
| RECTOR | LIBERTY MI | | L CENTI | EK_ | | DA | 7.1.1.1 | .NOM. | E) | | | | | |
| E | | 10b. COUNTY | | | 10c. Cl | TY, TOWN C | R LOCAT | TION | | | | | | 10d. INSIDE CITY |
| 100 | MD. | | | | 3/ | ALTI | MOR | E CI | TV | | | | | LIMITS? |
| 甘 | 104. STREET AND NUMBER | | | | | 120 2 2 2 . | | . ZIP CODE | | | | 10g. CITIZ | ZEN OF | WHAT COUNTRY? |
| E | 6739 TOWNB | ROOK | E DRIVE | | | | | 212 | 0.7 | | | | S.A | |
| FUNERAL | 11. MARITAL STATUS | | 12. WAS DECEDEN | IT EVER IN | U.S. ARMED | 13. 1 | WAS DEC | | | IC ORIGI | N? (Specify Yes | | 14. BAC | E - American Indian |
| BY F | 1/ Never Married 2 M | | FORCES? 1 IF YES, GIVE W | | | | f yes, sp | ecify Cuba | n, Mexicar | , Puarto | Rican, atc.) | | Spec | ck, White, etc. |
| | 3 Widowed 4 Divorc | ed | | | 71 | | | | | | | | - Cpr | ,- |
| TED | 15. DECEL (Specify only i | DENT'S EDUC | CATION completed) | | 16a. DECEDENT'S | work done o | CCUPATIO | ON ast of workin | ia | 168 | . KIND OF BUS | SINESS/IND | USTRY | |
| LETI | Elementary/Secondary (0-1 | 12) | College (1-4 or 5 | +) | life. Do NOT L | ise retired.) | | | • | | | | | |
| MP | n/a | | n/a | | n/a | | | | | | n/ | a | | |
| COMPL | 17. FATHER'S NAME (First, Mide | | | | | | | 18. MOTH | IER'S NAI | AE (First, | Middle, Malden | Sumame) | | |
| BE | LINWOOD DO | | | | | | | ROS | E Do | NWC | S | | | |
| 10 | 19a. INFORMANT'S NAME (Typ | | | | 19b. MAILIN | ADDRESS | (Street a | and Number | or Rural A | oute Num | ber, City or Tow | n, State, Zip | Code) | |
| - | ROSE DOWNS | | | | 6739 | TOI | INBI | ROOK | E DI | RTVI | H, | | | |
| | 200- METHOD OF DISPOSITIO | N 3 □ Remo | oval from State | 20b. | PLACE AND DATE | OF DISPOS | | | | DAT | | CATION — C | City or To | own, State |
| | 4 Donation 5 Other (S | Specify) | | - AI | RBUTUS | MEM | . C | EMET | ERY | 9- | 10110 | 1 SU | LPH | UR SPR. |
| | 21. SIGNATURE OF FUNERAL | SERVICE LICE | ENDEE | | 4 | 22. | NAME AN | ND ADDRES | S OF FAC | ILITY | | | | |
| | LAN. | .) / | MLL | 12/ | 1, | T. |) | T 0 4 | D D O 1 | | | 740 - | | |
| | IMMEDIATE CAUSE (Fina disease or condition resulting in death) | ert fallure. L | let Dnly one cau | ise on ea | the death. Do | not enter | the mo | de of dyl | KKOI | aa can | diec or respi | ratory arre | eat, | Approximat Interval Bat |
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| BALTIMORE, MARYLAND 21215-0020 | nours after death. Page 6 may be retained by the hospital or attending physician. | s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ith the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
|---|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with nours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal. |

| | 1 - STATE REGISTRAR | STATE OF I | MARYLAND C | / DEPAF ERTIF | | | | | MENTA | L HYGIENI REG. NO. | E | | |
|--------------------------|---|--|--------------------------------|------------------|--------------|------------------|-------------------|--------------------|------------------|------------------------------------|-----------|------------|--|
| | 1. OECEDENT'S NAME (First, Middle, Last) | Q ~T | 1 | λι | 2 4 | 11/2 | -/ |) | 2. DATE | OF DEATH | Y | YEAR | 3. TIME OF OEATH |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | L . | DL | 1/ | Kt | - K | | SG | TEMBE | R.2 | 1994 | 6-120 |
| | 220–14–7571 | 1 M 2 X F | 6. AGE (In yrs. le | YRS. | MONTHS | DAYS | HOURS | MIN. | (Mont) | of BIRTH h, Day, Year) 19/25 | | Country | PLACE (State or Foreign |
| | 9a. FACILITY NAME (If not institution, give | atreet and number) | | | 9b. CIT | Y, TOWN O | R LOCATI | ON OF DE | <u> </u> | 13/23 | 9c. COU | DOLL OF DE | imore, Md. |
| <u>۳</u> | Good Samaritan Hosp | The state of the s | | | | | | | | | | | |
| 5 | RESIDENCE OF DECEDENT | | | | | | | | | | | | |
| DIRECTOR | | | imme | | | | | | | LIMITS? | | | |
| | 10e. STREET AND NUMBER | Daltilliole 1 ☐ YES 2 🕅 NO | | | | | | | | | | | |
| ERA | 2309 Wilker Avenue | There A | | | | | | | | | | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Year or No. 14. BACE - American Indi | | | | | | - American Indian, | | | | | |
| B | 1 Never Married 2 Married 3 Wildowed 4 Divorced | | | | | | | y: | | | | | |
| <u> </u> | 15. DECEDENT'S EDI (Specify only highest grad | UCATION le completed) | 1 (| ECEDENT'S | work done | during mos | N st of workin | na | 16b | . KIND OF BUS | INESS/IND | USTRY | |
| COMPLETED | Elamentary/Secondary (0-12) | College (1-4 or 5 | +) | fe. Do NOT u | se retired.) | | | | | | | | |
| COMP | 10 Homemaker Housekeeping | | | | | | | | | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surmame) John Richard Shanaman Jourise Olga Finster | | | | | | | | | | | | |
| BE | John Richard Shanaman Louise Olga Finster 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | | | |
| 2 | Marie S. Leach 8117 Loch Raven Blvd. Baltimore, Md. 21286 | | | | | | | | | | | | |
| | 20b. PLACE AND DATE OF DISPOSITION DATE 20c. LOCATION — City or Town. State | | | | | | wn, Stata | | | | | | |
| | 4 - Donation 5 - Other (Specify) Dulaney Valley mem. Gdns. 9/6/94 Baltimore, Maryland | | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | | | |
| | Lassahn Funeral Home 7401 Belair Road Baltimore md. 21236 | | | | | | | | | | | | |
| CERTIFICATION | disease or condition reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated evente resulting in death) LAST LATER DEPART HEAMORITHACE 24THS DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| BY PHYSICIAN: MEDICAL CE | PART II, Other significent conditio | ns contributing to | deeth but not | resulting | in the u | nderlylng | g ceuse (| given in | Part I. | 24a. WAS AN PERFOR | MED? | 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| IAN | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | | | | | |
| /Sic | EXAMINER? 1 YES 2 NO | HOSPITAL: | ER/Outpatient | 3 🗆 DOA | OTHE 4 Nu | R: rsing Home | 9 5 □ Ra | sidenca | 6 Othe | r (Specify) | | | |
| PH | 27. MANNER OF DEATH | 26a. DATE OF (Month, E | | 28b. T/N | | 28c. INJU | | | 28d. DES | SCRIBE HOW IN | JURY OC | CURED | |
| BY | 2 Accident Investigation | 1 Natural 5 Pending (Month, Dey, Year) INJURY WORK? 1 YES 2 NO | | | | | | | | | | | |
| TED | '3 Suicide 6 Could not be 4 Homicide detarmined | 28a. PLACE C building, | of INJURY — At hate. (Specify) | nome, farm, | atreet, fac | tory, office | 1 | | 281. LOC City | ATION (Street a or Town, State) | nd Number | or Rumi A | oute Number, |
| COMPLETED | one! | SICIAN: To the bast of ER: On the basis of a | | | | | | | | | | | and manner as stated. |
| | 29b. SIGNATURE AND TITLE OF CERTIFIE | | / | | | , 1 | | ENSE NUN | | | | | (Month, Day, Year) |
| O BE | 1 | 500 | 100 | |) M | | P | -0 | 72 | 3 | 15 | 97 | ,02,94 |
| 10 | 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CAU | SE OF DEATH (IT | EM 217 (Type | Print) | 01 | 20 | CH | - RI | WEN | BI | VD. | 21239 |
| | 31. DATE "SEP" 0°8 1994 | | AR'S SIGNATURE | del. | | | | | | | | | |

permit. page 5 should be detached for use as the burial-transit retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 ours after death. Page 6 may be filled in by the funeral director, executed with death certificate be the atten Mental

CERTIFICATE OF DEATH BEG. NO 5-94 YEAR t. DECEDENT'S NAME (First, Migdle, Last) MARY DUNN, ANNE 0.S.F. 2. DATE OF DEATH 3. TIME OF OFATH MARY 94 050 MM 09 A SOCIAL SECURITY MIMBER 6. AGE (In yrs. 5 SEX lest birthday IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreig 1 M 2 DE 11 02 New York Se. FACILITY NAME (If not institution, give stre 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Pages 1, 2, 3 Mercy Hospital Baltimore na RESIDENCE OF DECEDENT 10e. STATE 10c, CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland Baltimore 1 YES 2 NO 100. STREET AND NUMBER Convent FUNERAL 10g, CITIZEN OF WHAT COUNTRY? 3725 Ellerslie Avenue 21218 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yea, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried If yes, specify Cube Specify Spec//y: White BY 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16b. KIND OF BUSINESS/INDUSTRY Elementery/Secondary (0-12) College (1-4 or 5+) 12 +Teacher Elem/Highsch Education 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Peter F. Dunn Ħ Anna Bowes Johnson BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Sister Tan 3725 Ellerslie Ave, Balto, MD21218 be 20s. METHOD OF DISPOSITION 20c. LOCATION -- City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must 1 Buriel 2 Cremation 3 Removal from State
4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE DO nald Wade, Dit 22. NAME AND ADDRESS OF FACILITY examiner State Anatomy Board Wells 655W.Baltimore St, Balto, MD21201 unasi medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, Dr heart failura. List Dnly Dna cause Dn aach line. Interval Between Onset and Death 6 IMMEDIATE CAUSE (Final the diseese Dr condition attending physician and completely intal Hygiene prior to burial, crematic acute Cardiac arrest mmedial resulting in daeth) event, DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEQUENCE OF alherosclerotes cardinasculas descrip traumatic CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL this certificate has been signed by with the State Dept. of Health and hypertension апу 1 TES 2 NO DF DEATH? shows ostevastaretis 1 TES 2 NO PHYSICIAN: HOSPITAL OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER:
4 | Nursing Home 5 | Residence 8 | Other (Specify) 10 27. MANNER OF GEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Netural 5 Pending Investigation 1 YES 2 NO BY DIRECTOR: After the hours after death tem 28 is man 2 Accident 28e. PLACE OF INJURY — At home, ferm, streat, fectory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town. State) 3 Suicide 8 Could not be COMPLETED 4 Homicide 29e. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner as stated. FUNERAL Within 72 h = 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 023820 Sumarl 94 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MCCORMACK 21202 GREGORY MERCY HOSPITAL 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

_ 8 1994

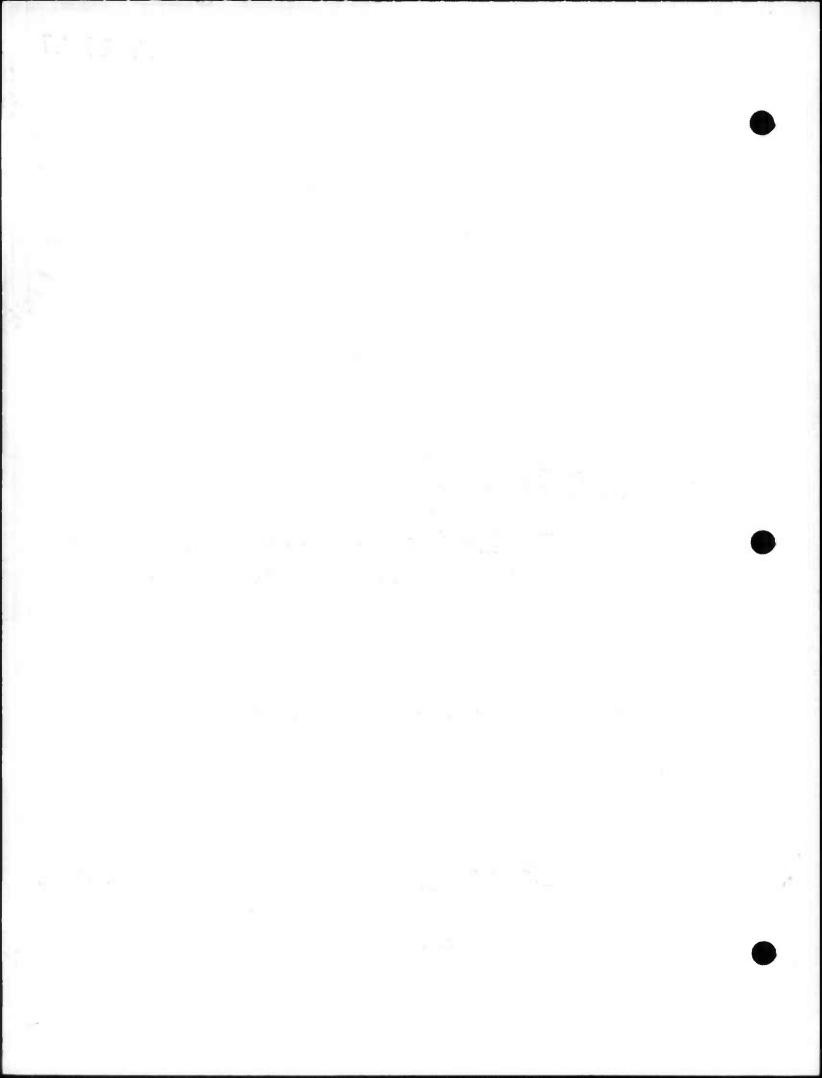
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SEP 8 1994

DIVISION OF VITAL RECORDS, P.O.

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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|--|

| | REGISTRAR | | CE | RITE | CALE | UF | DEAL | П | REG. NO |), | | |
|---------------|--|---------------------------|--|-------------------|---------------|----------------|---------------------|-----------|--|-------------------|------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Lulu DeNault | | | | | | | | 2. DATE OF DEATH MONTH September | ΑΥ _E 1 | 0,75% | 7:00 P M |
| | | | | | | | | | | 0, 1 | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. lest | - " | IF UNDER 1 | YEAR DAYS | IF UNDER | 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTHPI Country) | LACE (State or Foreign |
| | 075-09-7982 | 1 M 2 K F | 90 | YRS. | - Contract | DATE | HOOKS | mire. | May 9, 19 | 04 | | York |
| | 9e. FACILITY NAME (If not institution, give si | | 9b. CITY, | TOWN C | R LOCATIO | N OF DE | ATH | 9c. COL | INTY OF DEA | ATH | | |
| H. | 3359 Old Line Ave | nue | | | La | ure | 1 | | | Δ | nne A | rundel |
| DIRECTOR | RESIDENCE OF DECEDENT | | | | | | | | | | 111110 11 | Tundel |
| 3 | 10e. STATE 10b. COUNTY | , | | 10c. CITY | , TOWN OF | LOCAT | ION | - | | | 1 | IGH. INSIDE CITY |
| <u>=</u> | Maryland An | ne Arund | el | | La | ure | 1 | | | | | LIMITS? |
| | 10e. STREET AND NUMBER | | | | | | ZIP CODE | | | 10a, CIT | | AT COUNTRY? |
| FUNERAL | 3359 Old Line Ave | | | | | | 20. | 70/ | | | | |
| Z I | 11. MARITAL STATUS | | IT EVER IN U.S. ARM | er in | 40.00 | | | 724 | | <u> </u> | USA | |
| | 1 Never Merried 2 Merried | FORCES? 1 | YES 2 V NO | EU | | | | | HC ORIGIN? (Specify Yen, Puerto Rican, etc.) | e or No— | | - American Indian, White, etc. |
| ВҰ | 3 👽 Widowed 4 🗌 Divorced | IF YES, GIVE V | WAR OR DATES | | 1 | YES | 2 X NO | Specify | r: | | Specify: | White |
| | 15. DECEDENT'S EDUC | CATION | Tie. nee | | 1 | | | | | | | |
| COMPLETED | (Specify only highest grade | completed) | (GM | | ork done du | | nn st of working | 7 | 16b. KIND OF BU | SINESS/IN | DUSTRY | |
| ۳ | Elementery/Secondary (0-12) | College (1-4 or 5 | +) | | | | | | | | | 3 |
| Z | 8 | Ø | | Line | Work | er | | | | | uring | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 16. MOTH | ER'S NAI | ME (First, Middle, Melder | Sumeme) | | |
| BE | John Haver Maggie Schoonmaker | | | | | | | | | | | |
| 0 | | | | | | | | | | | | |
| F | Marion Fancher | | 33 | 359 (| old L | ine | Aver | nue. | Laurel, 1 | Marvl | and 2 | 0724 |
| | 20e. METHOD OF DISPOSITION | | 20b, PLACE AL | ID DATE O | F DISPOSIT | TION (Na | me of | | | | City or Town | |
| 1 | 1 Donetion 5 Other (Specify) | oval from State | cemetery, crem | LOSET | ner place) | Cem | eters | r | N. | N. Vo | rk | |
| - 71 | New TOTA | | | | | | | | | | | |
| | 22. NAME AND ADDRESS OF FACILITY Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, MD 20707 | | | | | | | | | | | |
| | Cesal | July | auce | | | | | | | | | MD 20/07 |
| | 23. PART Enter the diseases, or o shock, or heart failurg. | omplications the | s counsed the des | th. Do n | ot enter t | he mo | de of dyir | ng, such | h as cardiac or resp | iratory ar | rest, | Approximate |
| | IMMEDIATE CAUSE (Final | List only one cat | on eacy line. | 14 | | | 0 | | , 0 | | | Onset and Death |
| - 1 | disease or condition | Di | ONA | 7 | NO | L. | 40 | 201 | I to | Desa | 0 | |
| | resulting in death) | DUE TO | OR AS A COMMEDI | HENCE OF | V | - | 000 | · · | 1. | ano | _ | 1 |
| - | _ | A | eninch | 0 | 045 | Ti | - 0 | 100 | (K) Hay | 1000 | 10 | İ |
| õ | Sequentially list conditions, | DUE TO | OR AS A CONSECU | JENCE OF | yw. | 14 | - T | 100 | NO JO | MCC | // | 1 |
| A. | If any, leading to immediate cause. Enter UNDERLYING | Pari destati | | | 0.0 | | | | | | | 1 |
| 윤 | CAUSE (Disease or Injury that initiated events | DUE TO | OR AS A CONSEQU | JENCE OF | i i | | | | | | | 1 |
| E | resulting in death) LAST | | | | | | | | | | | 1 |
| CERTIFICATION | - C | | | | | | | | | | | |
| | PART II. Other significant condition | s contributing to | death but not re | sulting is | the und | Serlying | cause g | iven in i | Part I. 24s. WAS AF | | | VERE AUTOPSY FINDINGS |
| EDICAL | | | | | | | | | PERFO | | | WAILABLE PRIOR TO COMPLETION OF CAUSE |
| 8 | F | | | | | | | | T T YES | L MO | - 0 | OF DEATH? |
| 2 | DID TODA COO | | | | | | | | | | 1 | ☐ YES 2 ☐ NO |
| PHYSICIAN: | DID TOBACCO USE | CONTRIBUT | E TO CAUS | E OF | DEAT | _ | | NC | | | | |
| 2 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL; | | Т | OTHER | | ACE OF DE | ATH (Che | eck only one) | | | |
| XS | 1 YES 2 NO | 1 Inpatient 2 | ER/Outpatient 3 | | | | s 5 ☐ Res | sidence | 6 Other (Specify) | | | |
| H | 27. MANNER OF DEATH | 28e. DATE OF (Month, D | | 28b, TIME INJU | | 28c. INJ WO | URY AT RK? | | 28d. DESCRIBE HOW | OO YRULNI | CURED | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | | | | M | | 'ES 2 _ | NO | | | | |
| ED | 3 Suicide 6 Could not be | 26e. PLACE C | F INJURY At horr atc. (Specify) | e, ferm, s | treet, facto | ry, offici | , | | 261. LOCATION (Street | | r or Rural Ro | ute Number, |
| | 4 Homicide determined | | uses (opcomy) | | | | | _ | City or Town, State | , | | |
| ۳ ا | 29e. CERTIFIER | CIAN: To the heet of | my knowledge des | th agreement | d =0 0b = 0l= | | | | | | | |
| ₹ | (Check only one) 2 MEDICAL EXAMINE | | | - 4 | | | | | to the cause(e) end ma | | | |
| COMPLET | | 0 | Aminimation endor in | // Janior | i, in my op | inion, o | earn occur | Id at the | time, date end place, e | nd due to t | he ceuse(e) | and menner ee stated. |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIES | Sec al | muly | 1 |) . · | | 29c. LICE | NSE NUM | BER | 29d, DA1 | E SIGNED | Month, Day, Yeer) |
| | (69 | see | The state of the s | 0 | Juy sic | 1ag | 0 | 08 | 307 | | 6 4 | 20794 I |
| 2 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLET D PAU | SE OF DEATH (ITEM | 27) (Type, | Print) | | 0 | | 1 - | | ~ ~ | 1 |
| | DRTAKY MO | URT21 | ANAKUS | | 345 | U | toit | He | ede Pd | , L | aurel | (M) |
| | 31. DATE FILED (Month, Day, Year) | | R'S SIGNATURE | | | | - 1 | | | 1 | | |
| | SEP 0 8 1994 | | bear Randall | ! | | | | | | | | |
| | VI V 0 1354 | 7 | - and a district | | | | | | | | | |



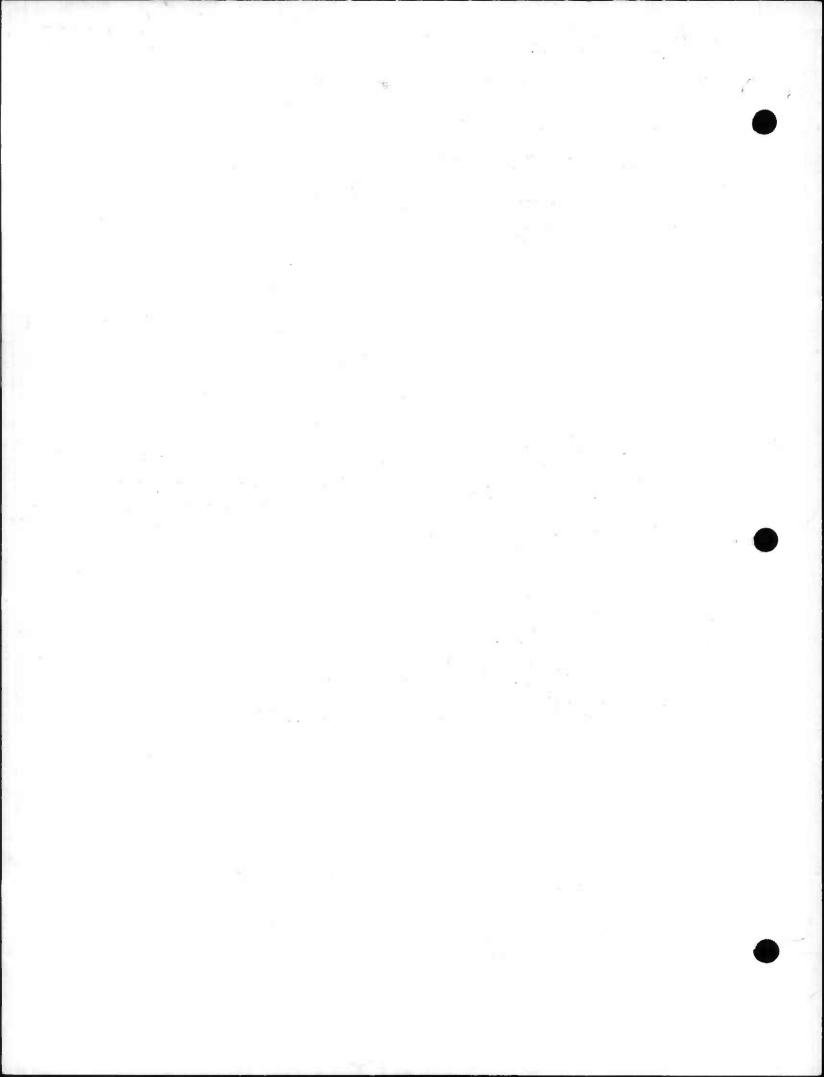
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| | | d completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should |
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| BALTIMORE, MARYLAND 21215-0020 | 8 | = |
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| | cuted with. Cours after death, Page 6 may be retained by the hospital or attending physician, | 43 |
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL AND DING PHYSICIAN: The law requires that the death certificate be executed with ours after death. Page 6 may be retained by the hosp TO THE FUNEM. OHE THE FUNEM CHEEK A STEET After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filled within the State Dept. Of Health and Mental Hyglene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
|-----|---|----------|
| | | HIGHERIE |
| RAR | CERTIFICATE OF DEATH | REG. NO. |

| | REGISTRAR | | CERTIFIC | CATE OF | DEATH | REG. NO | | | |
|---------------|--|--|--|-------------------|------------------------|---|---------------------|-------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | |
| - 65 | CHARLES W | ILLIAM EI | LTON | | | 0 | AY . | YEAR 2/:30 M | |
| | 4. SOCIAL SECURITY NUMBER | | | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | 8. BIRTHPLACE (State or Foreign | |
| 1 | 213-16-5779 | 1 KM 2 G F 81 8 | YRS. | ONTHS DAYS | HOURS MIN. | (Month, Day, Year) | 113 | Country) | |
| | 9a. FACILITY NAME (If not institution, give stre | eet and number) | | b. CITY, TOWN | OR LOCATION OF DE | | 9c. COU | INTY OF DEATH | |
| Œ | ST Agnes | Hospital | | | | | 1 | | |
| 띩 | ST Agnes Hospital BALTIMORE 1 | | | | | | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LOCA | TION | | | 10d. INSIDE CITY LIMITS? | |
| | Maryland Baltin | more | Ca | tonsvi | .11e | | | 1 YES 2 NO | |
| AL | 10a. STREET AND NUMBER | | | 10 | M. ZIP CODE | | 10g. CIT | TIZEN OF WHAT COUNTRY? | |
| E E | 707 Maiden Choice | ice Lane, Apt. 9T21 21228 United States | | | | | | | |
| FUNERAL | | STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No. 14. RACE — American Indian, | | | | | | | |
| | 1 Never Married 2 Married | Married FORCES? 1 YES 2 NO If yes, specify Cuban, Maxican, Puerto Rican, etc.) Black, White, atc. | | | | | | | |
| ВУ | 3 Widowed 4 Divorced | Widowed 4 Divorced White | | | | | | | |
| 핃 | 15. DECEDENT'S EDUCA (Specify only highest grade of | | 16a. DECEDENT'S US | NAL OCCUPAT | ION lost of working | 166. KIND OF BU | SINESS/INI | DUSTRY | |
| <u> </u> | Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of wor | | | | | | |
| ₽ P | 6 | | Boat Car | penter | | Boat | Const | truction | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Maiden | | | |
| 8 | Charles William Elton Henrietta Winifred Leach | | | | | | | | |
| 2 | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | |
| | Bertha A. Elton | | 707 Ma | iden C | hoice Ln. | , Apt. 9T | 21, 0 | Catons. MD 21228 | |
| | 20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION — City or Town, State | | | | | | City or Town, State | | |
| | Glen Haven Mem. Pk. 9-9-94 Glen Burnie, Maryland | | | | | | | | |
| | 21. BIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | |
| | Kirkley-Kuddick Funeral Home | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | |
| | shock, or heart failure. Li | ist only one cause on as | nch lina. | | | | | Interval Between Onset and Death | |
| | IMMEDIATE CAUSE (Finel disease or condition | Canada | Ho | 20+ | E.1.10 | | | A | |
| | resulting in death) a. | Conges + | CONSEQUENCE OF: | 4/1 | railure | | | 197 | |
| - | | Cacabanda | sc. lar | Accie | lent | | | 100 | |
| CERTIFICATION | Sequentially liet conditions, if any, leading to immediate | Cerebio Vu | CONSEQUENCE OF): | 7 | | | | 10 gays | |
| CA | ceuse. Enter UNDERLYING | Atrial P | | | | | | 15 yrs | |
| E | CAUSE (Disease or Injury that initiated evente | | | | | | | | |
| E | resulting in deeth) LAST | Myo care | lial Ir | Ferct | (40) | | | 10 Yrs | |
| | PART II. Other eignificant conditions | contributing to death by | ut not resulting in | the medealule | | D. 1 | | | |
| DICAL | | | | | | PERFOR | RMED? | AVAILABLE PRIOR TO | |
| | Α | ependent | trabet | esine | ling | 1 _ YES 2 | NO | OF DEATH? | |
| ME | Horte AN | leury sm. | | | | | | 1 TYES 2 NO | |
| ä | DID TOBACCO USE (| CONTRIBUTE TO | CAUSE OF | DEATH | YES NO | | | | |
| PHYSICIAN: | | HOSPITAL: | | 26. F | PLACE OF DEATH (Che | ack only one) | | | |
| ΥS | 1 TYES 2 X NO | 1 🗂 Inpetient 2 🗆 ER/Outpu | | | me 5 🗆 Residence | 6 Other (Specify) | | | |
| F | 27. MANNER OF DEATH 1 Natural 5 Pending | (Month, Day, Year) | 28b. TIME (| | JURY AT ORK? | 28d. DESCRIBE HOW I | NJURY OC | CURED | |
| B | 2 Accident Investigation | | | | YES 2 NO | | | | |
| | 3 Suicide 8 Could not be 4 Homicide determined | 28s. PLACE OF INJURY building, atc. (Speci | At home, farm, stre ify) | et, factory, offi | Ca | 281. LOCATION (Street a City or Town, State) | and Number | or or Rural Route Number, | |
| | 4 Homicide determined | | | | | | | | |
| P. | 29a. CERTIFIER 1 CERTIFYING PHYSICI | IAN: To the best of my knowle | edge, death occurred | at the time, dat | a and placa, and dua | to the cause(a) and made | nor ea ata | ited. | |
| COMPLETE | one) 2 MEDICAL EXAMINER | On the basis of examination | and/or investigation, | In my opinion, | death occured at the | time, data and place, an | d due to ti | he cause(a) and manner as stated. | |
| Ш | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUM | IBER | 29d, DAT | TE SIGNED (Month, Day, Year) | |
| ∞ | of Me | SURGIO | CAL RE | SINGIT | | 7 | • | 9/6/94 | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETEO CAUSE OF OE | ATH (ITEM 27) (Type, Pi | int) | | + | L | 1/0/11/ | |
| | Hadi Rassae | 900 | CATON | A | re | Baltimor | re, | , CD, | |
| | SEP 0 8 1994 July September 1994 | | | | | | | | |



TO BE COMPLETED BY FUNERAL DIRECTOR

| FOR STATE REGISTRAR | STATE OF MARY | YLAND / DEPARTA CERTIFIC | MENT OF HEALTH AN | ND MENTA | AL HYGIENE REG. NO. | | | |
|--|---|---|--|------------------|---|------------------------|--|----------|
| 1. DECEDENT'S NAME (First, Middle, Last) | Antwan Mau | | | 2. DAT | E OF DEATH | | . TIME OF DEATH | |
| Antoine | | Ford | | Se | | 994 | 0255 | M |
| 4. SOCIAL SECURITY NUMBER 216 - 92 - 9820 | 5. SEX 6. AC | | UNDER 1 YEAR IF UNDER 24 INTHS DAYS HOURS IN | | E OF BIRTH with, Day, Year) -13-78 | 8. BIRTHPL Country) | ACE (State or Foreig | 10 |
| 9e. FACILITY NAME (If not institution, give s | | 1 | CITY, TOWN OR LOCATION | OF DEATH | 9c. COI | INTY OF DEA | ту | |
| 400 blk. E. Lo | <u>rraine Av</u> | enue | Baltimo | re | | | | |
| 10a. STATE 10b. COUNTY | 1 | 10c. CITY/T | OWN OR LOCATION | | | 1 | Od, INSIDE CITY | |
| MATY/AM | | BA | 1/Imore | | | 1 | YES 2 NO | |
| 3647 Keny | on A | y ei | 101. ZIP CODE 2/2/ | 13 | 10g. Cl | IZEN OF WH | AT COUNTRY | |
| 11. MARITAL STATUS 1 Nover Married 2 Merried | 12. WAS DECEDENT EVE FORCES? 1 1 Y | R IN U.S. ARMED | 13. WAS DECENDENT OF H If yes, specify Cuben, N | IISPANIC ORIGI | fN? (Specify Yes or No- | 14, RACE - Black, V | - American Indian, White, atc. | |
| 3 Wildowed 4 Divorced | IF YES, GIVE WAR OF | | | Specify: | , | Speaky: | 12ch | |
| 15. DECEDENT'S EDUC (Specify only highest grade | | tea. DECEDENT'S USI | done during most of working | 16 | b. KIND OF BUSINESS/IN | DUSTRY | | |
| Elementery/Secondary (0-12) | College (1-4 or 5 +) | We. Do NOT use no | (Vent | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | 5% | in met | 18MOTHER | S NAME (First, | Middle, Maiden Surname) | 000 | / | |
| 19 INFORMANT'S NAME (Tipo/Print) | - 1 | 19b. MAILINO AD | DRESS (Street and Number out | Aurel Route Nur. | mber, City or Town, State, Z | ip Code) | i | \dashv |
| MYS, DOVICE | Ford | 5350 | ST C/A | ir LA | ACTK BR | Itimor | emd21 | 272 |
| 1 Burial 2 Cremation 3 Remarks 4 Penalin 5 Other (Specify) | | 20b. PLACE AND DATE OF D cernetery, cremetery or other | | des 9 | 9 DAII | Marce | MAN | 1/2 |
| 21. SIGNATURE OF FUNERAL SERVICE LIC | SHIRE () | 007,47 | 22 NAME AND ADDRESS | of sycinity | FUNER | 13/ H | me | Icen |
| Hoseph L | Kuss | | 2522/11 | Vonth | Ave BA | 16 | 212/2/2 | 1/2 |
| 23. PART i. Enter the diseases, or of ehock; or heart failure. | omplications that ceu | sed the deeth. Do not | enter the mode of dying | , auch aa ce | rdiec or reapiratory a | rreat, | Approximate | |
| iMMEDIATE CAUSE (Finel disease or condition resulting in death) | . gursite | | n or-yes | | | | Interval Betw Onest and D | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST | с | S A CONSEQUENCE OF): | | | | | | |
| PART ii. Other algnificent condition | e contributing to death | n but not reculting in t | he underlying ceuse give | en In Part I. | 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | A) | ERE AUTOPSY FINDI MILABLE PRIOR TO OMPLETION OF CAUS F DEATH? | |
| DID TOBACCO USE CONTE | RIBUTE TO CAUSE | OF DEATH YES | □ NO □ UNCER | TAIN 🗆 | | 1 | YES 2 NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE OF DEATH (| | | | | | \dashv |
| 1 X YES 2 NO | HOSPITAL: 1 Inpatient 2 I ER/O | utpatient 3 DOA 4 | THER: Nursing Home 5 Reside | enca 8 XOth | er (Specify) ON S | tree | t | |
| 27, MANNER OF DEATH | 28a. DATE OF INJUF (Month, Day, Yea | 28b. TIME OF | | | SCRIBE HOW INJURY OF | | | |
| 1 Natural 5 Pending finvestigation | 9-2-9 | 4 02TOA | 4 - 4-1 | · Su | UBJECT 5 | HOT | | |
| 3 Suicide 8 Could not be determined | 28a. PLACE OF INJU building, atc. (S | | of, factory, offica | 281. LO 40 | CATION (Street and Number or Your, State) | or O O O | to Number, BAL | |
| 29e. CERTIFIER 1 CERTIFYING PHYSIC | | | t fhe time, date and placa, an | | 7 | ायुद्धा | Na 1208 | |
| | | | my opinion, death occured | | | | nd manner as stele | d. |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 0121.00 | | 29c. LICENS | | - L | | lonth, Dey. Year) | |
| 38. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF | DEATH (ITEM 27) (Type, Pril | 7() | C.M.E | . I Se | pt. | 02_1994 | \dashv |
| Margarita A. F | Korell, MI |). 111 Per | nn Street. | Balt | imore. Ma | rvla | nd 2120 | 1 K |

32. REGISTRAR'S SIGNATURE

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

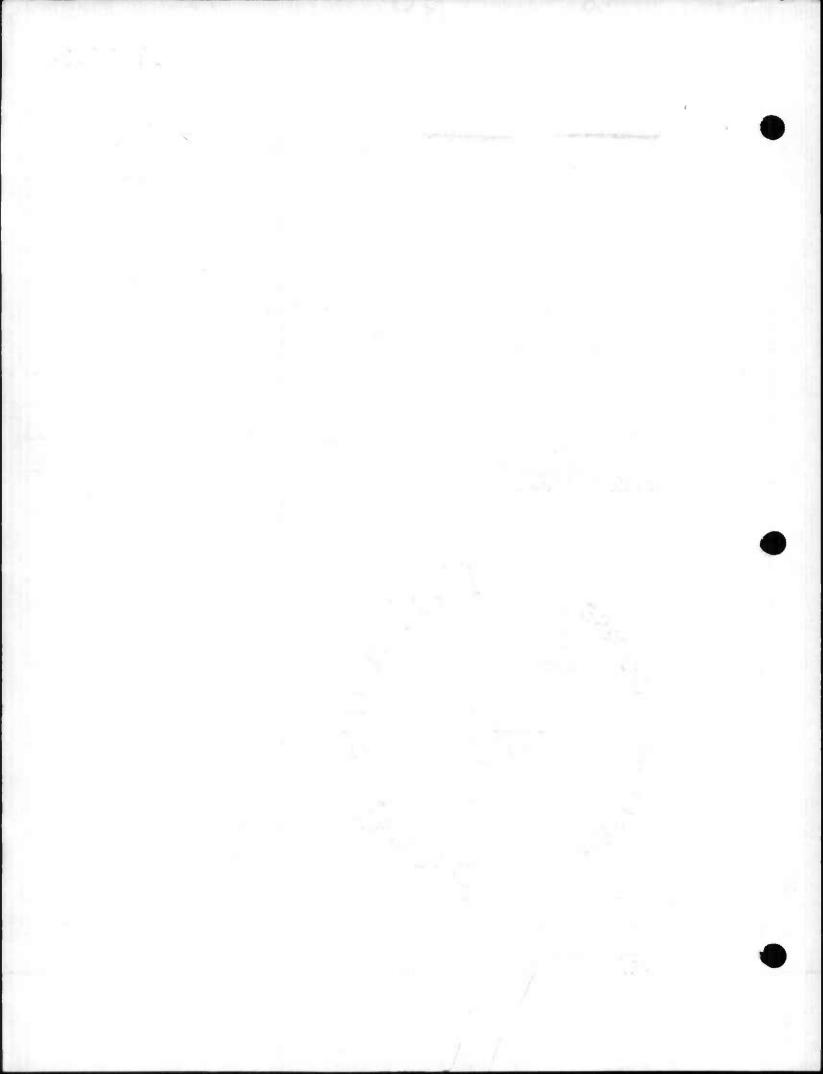
SEP 8 1994 SEP

DHMH-16 Rev 1/89

1 - STATE REGISTRAR

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CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH FLORENCE POLLACK FRIESS MONT 9 YEAR 7:10 1115 PM 6. AGE (In yrs. last birthday) 5. SEX 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 1 - M 2 -F 169-12-3023 June 1907 New York use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF CEATH DIRECTOR Charlestown Retirement N. Center Catonsville Baltimore Co. RESIDENCE OF DECEDENT 10a STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore County Catonsville 1 YES 2XXNO FUNERAL 10f, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY 701 Maiden Choice Lane 21228 USA nours after death, Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 NO 1 Never Married 2 Married 1 TES 2 NO Specify: BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) (Specify only highest grade comp page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) 12 years Accountant Auto Repair 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) notified at Horatio John Pollock BE Kate NMN 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Philip Allen Friess Pickburn Court Hunt Valley, MD 21030 Pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 1 Buriel 2X Cremation 3 Ren 4 Donation 5 Other (Specify) director, Cemetery Crematory of other place)
Metro Crematory 21. BIGHATUSE OF EURERAL SERVICE (ICENSEE Catonsville MD 21228 examiner 22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Road, Timonium, MD 21093 Martin the funeral D. Lawson medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, filled in by Approximata interval Between shock, or heart feliure. List only one ceuse on each ilne. 0 IMMEDIATE CAUSE (Final Onset and Death the disease or condition cremation, THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filed within 72 hours after death with the State Deor, of Health and Mental Hygiene prior to burial, cremativ resulting in death) executed within traumatic event, DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury other t DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 Injury, PART ii. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION DF CAUSE 24a. WAS AN AUTOPSY PERFORMED? ашу 1 TYES 2 NO OF DEATH? 23 shows 1 TYES 2 THO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 100 26. PLACE OF DEATH (Check only one) OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA e 5 🗆 Residence 6 🗆 Other (Specify) 4: N 6 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED Is marked, 1 Natural 1 YES 2 NO BY 2 Accident OR ATTENDING 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 28 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. IMPORTANT: IL 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year, BE 401 019 28 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) lebach 711 May 8/2 (40, G 96 9 31. DATE FILED (Month, Day, 1994



ours after death. Page 6 may be retained by the hospital or attending physician BALTIMORE, MARYLAND 21215-0020 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH SEPT 1994 10:40 Pm CONNIE FRANKLIN 05 LEE 6. AGE (In yrs. lest birthday) 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DAYS (49mh 59 my 300) 64 1 X M 2 F YRS. 246-36-0564 N.C 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF OEATH 9c. COUNTY OF DEATH DIRECTOR BALTIMORE CITY 1724 BRADDISH AVE RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTO MD XX YES 2 NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 21216 10g. CITIZEN OF WHAT COUNTRY? 1724 BRADDISH AVE U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1X XYES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yea, specify Cuban, Maxicen, Puerto Ricen, etc.)

1 YES XXNO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced BLACK COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired. st of working Elementary/Secondary (0-12) College (1-4 or 5+) JOHNS HOPKINS UNIV. MAINTENANCE TECH. 12TH 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) WILLIE FRANKLIN JESSIE 8 ADYLETT 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 ZELDA DORIS FRANKLIN 1724 BRADDISH AVE BALTO, MD 21216 20a. METHOD OF DISPOSITION
PL Burlel 2 Cremeflon 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata ARBUTUS "MEMORIAL PK 91094 ARBUTUS 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Glad MARCH F/H-WEST 4300 WABASH AVE ans 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, Approximate ahock, or heart fallure. List only one cause on each line. intarval Batween **IMMEDIATE CAUSE (Final** Onset and Death disesse pr condition Unoscho resulting in death) CERTIFICATION Sequantially list conditions, DUE TO OR AS A CONSEQUENCE OF) if sny, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (DR AS A CONSEQUENCE DF). that initiated evants resulting in dasth) LAST PART il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 | NO YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \$\Boxed\$ NO \$\Boxed\$ UNCERTAIN \$\Boxed\$\$ PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) OTHER: 1 X YES 2 | NO 4 Nursing Home 5 Residence 6 Other (Specify) Inpetient 2 - ER/Outpetient 3 - DOA 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) Found 9/4/94 26b. TIME OF INJURY 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 2 NO Lied 35HR 1 YES BY 2 Accident PLACE OF INJURY — At he building, etc. (Specify) 3 Sulcide COMPLETED 6 Could not be bathth 4 Homleide determined marcila 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated 2 XMEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(a) and manner ea stated. 296. SIGNATURE AND TITLE OF CERTIFIER O.C.M.E BE SEPT 05, 1994

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

THEODORE MIK

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111 Penn Street, Baltimore, Maryland 2120!

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within cours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - STATE OF MARY | LAND / DEPARTI CERTIFIC | MENT OF HEALTH AND I | MENTAL HYGIENI REG. NO. | E | 20002 | |
|--------------------|--|---|---|--|-----------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATN | | 3. TIME OF DEATH | |
| | CHRISTIAN LEIGH FRYE | | | AUL 2 | 9 1994 | 3:30 P H | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AG | | F UNDER 1 YEAR | 7. DATE OF BIRTH | 8. BIRTNE | LACE (State or Foreign | |
| | 578-36-2859 1 M 2 XF 7 | 7() YRS. | ONTHS DAYS HOURS MIN. | | | RALIA | |
| DIRECTOR | HOLY CROSS HOSPITAL | | SILVER SPRIN | | MONTGOMERY | | |
| EC | 10e. STATE 10b. COUNTY | 10c. CITY, 1 | TOWN OR LOCATION | | | 10d, INSIDE CITY | |
| - 1 | MARYLAND PRINCE GEORGE | | ADELPHI | | | LIMITS? | |
| FUNERAL | 100. STREET AND NUMBER 9004 RIGGS ROAD #6 | | 101. ZIP CODE 20783 | | 10g. CITIZEN OF WI | HAT COUNTRY? | |
| S | 11. MARITAL STATUS 12. WAS DECEDENT EVER | R IN U.S. ARMED | 13. WAS DECENDENT OF HISPAN | IIC ORIGIN? (Specify Yes | | - American Indian, | |
| ВУ Е | 1 Never Merried 2 Merried FORCES? 1 YES, GIVE WAR OR | DATES NO | If yes, specify Cuben, Mexice 1 YES 2 NO Specify | n, Puerto Ricen, etc.) | Black, | White, etc. WHITE | |
| TED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 16e. DECEDENT'S US (Give kind of wor | k done during most of working | 16b. KINO OF BUS | INESS/INOUSTRY | | |
| COMPLETED | Elementary/Secondary (0-12) College (1-4 or 5+) | HORSEWON | | FARM | ING | | |
| ő | 17. FATNER'S NAME (First, Middle, Last) | | 18. MOTNER'S NA | ME (First, Middle, Maiden S | Sumame) | | |
| BE (| CAPTAIN CHESTER WELLS | | MARIAN | LEIGH DIX | ON | | |
| 6 | 190. INFORMANT'S NAME (Type/Print) HERBERT JAMES FRYE | | PIMMIT DRIVE, F. | | | TA 22043 | |
| | 20a. METNOD OF DISPOSITION 1 Burlel 2XI Cremation 3 Removal from State | Ob. PLACE AND DATE OF | DISPOSITION/Name of | OATE 20c LOC | CATION — City or Tow | n State | |
| - 4 | 4 Donation 5 Other (Specify) | BALTIMORE V | VASHINGTON CREM | 9/4 LAU | REL, MARY | LAND | |
| | The state of the s | / | 22. NAME AND ADDRESS OF FA | | | | |
| - | 23. PART I. Enter the diseases, or complications that cause | W . | 7601 SANDY SP | | | MD 20/07 | |
| CERTIFICATION | iMMEDIATE CAUSE (Finei disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | S A CONSEQUENCE OF): | | level | | Approximete Interval Batween Onset and Daath | |
| | PART II. Other significent conditions contributing to death | hut and annulting in | Abo and delate and delate | | | 1 | |
| PHYSICIAN: MEDICAL | STATE OF THE STATE | out not resulting in | the underlying cause given in | Part I. 24a. WAS AN / PERFORI | MED? | WERE AUTOPSY FINDINGS AMARE AUTOPSY FINDINGS COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| X | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE OF OEATH (Che | ack only one) | | | |
| SIC | 1 YES 2 NO HOSPITAL: | | THER: Nursing Name 5 Residence | 6 Other (Specify) | | | |
| Y PH | 27. MANNER OF DEATN 1 Natural 5 Pending (Month, Day, Year Accident Investigation | | | 28d. OESCRIBE HOW IN | JURY OCCURED | | |
| ED BY | | RY — At home, term, stre | set, fectory, office | 281. LOCATION (Street or City or Town, State) | nd Number or Rursi Ro | oute Number, | |
| COMPLETED | 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the Seele of examinar | | | | | end manner ee stated. | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIER MUSEN X CULLUL | 140 | 20c. LICENSE NUN | IBER / | 29d. DATE SIGNED (| Month, Day, Year) | |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF I | DEATN (ITEM 27) (Type, Pr | int) 2309 M | TO RETIL | NO ZOS | · , | |
| | 31. DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIG | GNATURE | WNE | 11100019 | 2 | | |
| | 31. DATE FILEO (Month, Day, Year) SEP 0 8 1994 Julia Whenelian | rolandall | | | | | |

| BALLIMORE, MARYLAND 21215-0020 | in | FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | the medical examiner must be notified at once. |
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| DIVISION OF VITAL RECORDS, P.O. BOX 68/60, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within cours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fur be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

DIRECTOR

FUNERAL

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CERTIFICATION

MEDICAL

PHYSICIAN:

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COMPLETED

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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32. REGISTRAR'S SHOSATUREA

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH SAU MONTH CAMER :21 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH March 27,1906 Connecticut 578 60 4728 MONTHS DAYS HOURS 88 YRS. 1 XM 2 F 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Suburban Hospital Bethesda Montgomery RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Montgomery Chevy Chase 1 YES 2 770 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8100 Connecticut Ave. #908 20815 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 12 YNO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White atc. IF YES, GIVE WAR OR DATES 1 Never Married 2 Married It yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 YOO Specify: 3 Widowed 4 Divorced Carucasian 15. OECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Elementary/Secondary (0-12) College (1-4 or 5+) Attorney/Judge Law 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Samuel Gamer Bertha Resnik 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Gamer Perlman 3512 Rittenhouse Street, N.W. Wash., DC 20015 20a, METHOD OF DISPOSITION
1 Decial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Washington Hebrew Cemetery Washington, 4 Donation 5 Other (Specify) 21. SIGNATURE OF FRERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Ives-Pearson Funeral Homes Falls Church, Virginia 22046 ter the dispessa, or complications that caused the death. Do not enter the mode of dying, auch as cerdiec or respiratory errest, ock, or heart feliure. List only one cause on each line. Approximate interval Between iMMEDIATE CAUSE (Final disease or condition resulting in deeth) Onset and Death Sclerotic DUE TO (OR AS A CONSEQUENCE OF): Sequentielly list conditiona, OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury OUE TO (OR AS A CONSEQUENCE OF): that initiated eventa reaulting in deeth) LAST PART ii. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMEO? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 - YES 2 - NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) HOSPITAL . OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 27. MANNER OF DEATH 28b. TIME OF INJURY 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending 1 YES 2 NO 2 Accident 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Sulcide 6 Could not be 4 Homicide determined 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER. On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) Ook CON Due_ 31-5

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTION: After this centificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to bunial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
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| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAND | D / DEPARTING | | | MENTA | L HYGIENE | E | | | |
|------------------|--|---|---|---------------------|--------------------------------|--------------------|--|----------------|--------------|---------------------------|----------|
| | 1. OECEDENT'S NAME (First, Middle, Last) | | | | | | OF DEATH | V. XI | | TIME OF OEATH | |
| | ERMA VERN 4. SOCIAL SECURITY NUMBER | | | GREE | | SEP | | | | 10:25 | ₽. |
| 1 7 | | 6. AGE (In yrs | | TUNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN, | (Mont | of BIRTH h, Day, Year) 4, 19 | | Country) | CE (State or Forei | lgn |
| | 9e. FACILITY NAME (If not institution, give stree | | 91 | b. CITY, TOWN C | R LOCATION OF O | | 4, 19 | 9c. COUNTY | OF DEAT | | - |
| OR | 1401 LOCHNER RO | APT.B | | BALTI | MORE C | ITY | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | 10c. CITY, T | OWN OR LOCAT | ION | | | | 100 | 1. INSIDE CITY | - |
| | Maryland | | | B | altimore | 9 | | | 10 | LIMITS? | |
| FUNERAL | 1401 Lochner Road | Ant D | | 101 | . ZIP CODE | 14000 | | 10g. CITIZEN | | | |
| UNE | | 2. WAS DECEDENT EVER IN U.S. | . ARMED | 13. WAS DEC | ENDENT OF HISPA | 1239 NIC ORIGIN | 1? (Specify Yea | or No.— 14. | RACE - | USA American Indian, | |
| BY F | 1 Never Merried 2 Merried 3 Wildowed 4 Divorced | FORCES? 1 YES 2 | | | 2 X NO Specific | | Rican, etc.) | | Specify: | | |
| | 15. DECEDENT'S EDUCAT | TION 16e | . DECEDENT'S US | | | 16b | . KIND OF BUS | INESS/INDUST | | <u>hite</u> | \dashv |
| COMPLETED | | mpleted) College (1-4 or 5+) | (Give kind of work life, Do NOT use re | etired.) | st of working | | | | | | |
| MP | 17. FATHER'S NAME (First, Middle, Last) | | licket | Taker | | | | Movie | | | _ |
| | Logan Dunn | | | | Ida V. | | ^{Middle,} Maiden S Unknowr | | | | |
| TO BE | 19e, INFORMANT'S NAME (Type/Print) | | 19b. MAILING AC | ORESS (Street e. | nd Number or Rural | , | | | de) | | |
| F | Mrs. Karol M. Mani | | | | 's Mill | Road | | | | and 211 | 31 |
| | 20e. METHOO OF DISPOSITION 1 Buriel 2 Cremetion 3 Remove 4 Donation 5 Other (Specify) | I from State 20b. PLA | CE AND DATE OF D | placa) | corp. 9/ | O JOAT | E 20c. LOC | ATION — City | | | |
| 1 | 21. SIGNATURE OF FUNERAL SERVICE LICEN | oge / | i i cop se | | D ADDRESS OF FA | | 1 109 | vson | viar y | Lano | |
| | * Merking | Buck | | Leonard | J. Ruck, | Inc. | 5305 Hav | rford Ro | oad 2 | 21214 | |
| | 23. PART i. Enter the diseeses of con ehock, or heert fellure, Lis | nplicetions that caused the | deeth. Do not | enter the mo | de of dying, suc | h se cere | dac or reepir | atory arrest. | | Approximate interval Bets | |
| | iMMEDIATE CAUSE (Finel disease or condition | KTH-naccon | 10516 | ~ ~ ~ ~ ~ · | .D. DC 0 | ^ | -4 - 0 4- | A C 100 | _ | Onset and E | |
| | resulting in deeth) e | OUE TO (OR AS A CON | ISEQUENCE OF): | 1244) | 00000 | ııı | uo Dis | 261976 | | | \dashv |
| NO | Sequentielly list conditions, | DUE TO (OD AS A CO) | IOSOLISMOS AD | | | | | | | | _ |
| CATI | if sny, leeding to immediate csuse. Enter UNDERLYING | DUE TO (OR AS A CON | ISEOUENCE OF): | | | | | | i | | |
| TE | CAUSE (Disesse or Injury thet initiated events resulting In death) LAST | DUE TO (OR AS A CON | ISEOUENCE OF): | | | | | | | | |
| CERTIFICATION | d. | | | | | | | | | | |
| AL | PART ii. Other significent conditions of | contributing to death but no | ot resulting in t | he underlying | ceuee given in | Pert i. | 24e. WAS AN A PERFORA | | | RE AUTOPSY FIND | |
| EDIC | | | | | | | 1 TYES 2 | D16 | | WPLETION OF CAU DEATH? | SE |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRIE | SUTE TO CAUSE OF D | FATH YES | Пиоп | UNCERTAI | | INSB | 40 BZ | 1 [| YES 2 NO | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL | | LACE OF OEATH (| Check only one) | OTTERNAL | | | | | | |
| İ | 200 | ☐ Inpatient 2 ☐ ER/Outpatient | t 3 🗆 DOA 4 | | 5X Residence | | | | | | Щ |
| | 1 Natural 5 Pending | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | | RK? | 28d. DES | CRIBE HOW IN | JURY OCCURI | EO | | |
| D BY | 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE OF INJURY — At building, etc. (Specify) | t home, ferm, atre | et, factory, office | | | ATION (Street an | nd Number or R | Bural Floute | Number, | \dashv |
| ETE | 4 Homicide determined | | | ··· <u> </u> | | 0.1, | | | | | |
| COMPLETED | and the same of th | N: To the best of my knowledge, On the bests of examination end- | | | | | | | NIII. 225 | | |
| | 296 SIGNATURE AND TITLE OF CHARTIFIER | A 1 | vor investigation, i | n my opinion, de | 29c. LICENSE NUI | | and place, end | | | -77 | rd. |
|) BE | Mobilite me | Thele | | | O.C.M | | | ▶ SEI | PT 0 | 2,1994 | 1 |
| 2 | 30 NAME AND ADDRESS OF PERSON WHO C | | 111 D | onn C-l | reet, | R=14 | imoro | Mar | cv l = | nd 211 | 20 1 |
| | 31. DATE FILEO (Month, Day, Year) | ALONSW WY | | enn 51 | Teet, | раті | THOTE | , Mal | ТАТО | 212 | -01 |
| | SEP 0 8 1994 | Jalin Studenta | rdall | | | | | | | | |

State of the State

TO BE COMPLETED BY FUNERAL DIRECTOR

had, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BY PHYSICIAN: MEDICAL CERTIFICATION

BE COMPLE

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| 1 | | FOR STATE | | | | | | | | | | | | S | TA | TE | | OF | M | A | R | YI |
|---|----|--------------|---|---|---|---|---|---|---|---|---|---|---|---|----|----|---|----|---|---|---|----|
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| LA SCIONAL GENERAL SECURITY MANNERS 1.4 A SCIONAL SECURITY MA | FOR STATE REGISTRAR | , | STATE OF I | - | AND / | DEPAR ERTIF | TMEN | T OF I | HEALTH DEAT | AND TH | MENTA | L HYGIEN | | | | |
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| SOCIAL PLANSE S. EX. LAGE (Pr.) IN LANGE (Pr.) IN LANGE (PR. | | | EMANC | | | | | | | | 2. DAT | E OF OEATH | 2/2 | OYEAR | 3. TIME OF DEATHAM | |
| 114-36-5396 To May 20 53 ms. DOWN D | | | | | | | | | | | 5 | EPT 4 | 0 1 | | | M |
| See COTY TOWN ON LOCATION OF DEATH See COUNTY OF DEATH NAME PROVIDED TO SEE THE NAME PROVI | | | | | | | | 1 | | | 7. DATE (Mon | OF BIRTH th, Day, Year) | | 6. BIRTH Count | IPLACE (State or Foreign | |
| UNIVERSITY MD. S.T.U. BALTIMORE CITY IN/A INSERTING COUNTY WARYAINAND IN STREET AND NUMBER 10193 Cape Ann Drive In Street And County In Street And C | 114-36-3396 | | 1 M 2 X F | 53 | | YRS. | | | | | Nov | .25,19 | 40 | Gerr | nany | |
| See SERVE The COUNTY See TOTAL See Name The County See TOTAL See Name The County See TOTAL See T | 9a. FACILITY NAME (If not in | stitution, give st | treet and number) | | | | 9b. CIT | Y, TOWN | OR LOCATE | ON OF D | EATH | | 9c. COL | INTY OF D | EATH | |
| Maryland Howard County 10-93 Terrer AND NUMBER 10-193 Cappe Ann Drive 21046 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND County 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND COUNTY Cormany 10-95 Citizes or WAND County Cormany 10-95 Citizes or WAND County Cormany 10-95 Citizes or WAND County 10-95 Citizes or WA | UNIVERS: | ITY M | D. S.T. | U. | | | E | ALT | IMOR | E C | ITY | | n, | /a | | _ |
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| 10193 Cape Ann Drive 11. MARTIAL STATUS 11. WAS DECEMENT EVER IN U.S., ARMSED 12. WAS DECEMENT OF HIS ARMS OF THE PROPERTY IN THE PROPERTY | | Howa | rd Count | У | | | (| Colu | mbia | | | | | | | |
| 1. Note Section of Personal Control (1982) 1 (1982) 2 (1982) 1 (1982) 2 (19 | | Ann D | rive | | | | | 10 | of. ZIP CODI | E | 2 | 1046 | | | | |
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| Significant conditions. Significant condition | | Married | FORCES? 1 | YES | 2 P | 10 | " | If yea, s | pecify Cuba | n, Maxica | an, Puerto | | or No- | Black | k, White, atc. | H |
| College (I do of s.) College (I do of s.) College (I do of s.) College (I do of s.) College (I do of s.) College (I do of s.) Physicians Assist. Health Care | 3 Widowed 4 Divo | rced | IF YES, GIVE V | WAR OR DA | ATES | | | 1 YE | S 2 ZLNO | Specif | fy: | | | Speci | | |
| Emeratory@scordary (0-12) Physicians Assist. Health Care Physicians Assist. Health Care 17. FATNER'S NAME (First, Middle, Last) Heinrich Scharff 18. MOTHER'S NAME (First, Middle, Maidlen Sumann) Hannah (unknown) Mr. Albert Genemans 10193 Cape Ann Dr., Columbia, MD 21046 10193 Ca | 15. DEC (Specify only | EDENT'S EDUC y highest grade | CATION completed) | | 16a. DE | CEDENT'S | USUAL (| OCCUPATION OF THE PROPERTY OF | ON ost of workin | na | 16 | b. KIND OF BUS | SINESS/IN | DUSTRY | | |
| 17. PATHER'S NAME (First, Middle, Mackin Sumanus) Heinrich Scharff 18. MOTHER'S NAME (First, Middle, Mackin Sumanus) Hannah (unknown) 19. MAILING ADDRESS (Sized and Number of Part Route Number, Cot and Country) Mr. Albert Genemans 10193 Cape Ann Dr., Columbia, MD 21046 28. METHOD OF DEPOSITION Well and Consequence of Columbia (Cot and C | Elementary/Secondary (0 | 1-12) | College (1-4 or 5 | +) | life. | Do NOT us | se retired. |) | | | | Hoa1+1 | ı Cai | | | |
| Heinrich Scharff 198. MALENDROMANT'S NAME (Propring) 199. MALENDROMANT'S NAME (Propring) 190. MALENDROMANT'S NAME (Propring) 190. MALENDROMANT'S NAME (Propring) 190. MALENDROMANT'S NAME (Propring) 190. MALENDROMANT'S NAME (Propring) 190. MALENDROMANT'S NAME (Propring) 190. MALENDROMANT'S NAME (Propring) 190. MALENDROMANT'S NAME (Propring) 200. PLACEARD GALEARD GALEARD GALEARD OF DISPOSITION/Name of Country or Town, State Country or Davie, State Cou | | | | | | | | | | | | | | | | |
| Mr. Albert Genemans 10193 Cape Ann Dr., Columbia, MD 21046 30 PLACEAND OR FOR POSTION **Columbia Date | | Hoinrich Cohowes | | | | | | | | | | | | | | |
| May Albert Genemans 10193 Cape Ann Dr., Columbia, MD 21046 | 19a, INFORMANT'S NAME (7 | ype/Print) | | | 198 | . MAILING | ADDRES | SS (Street | and Number | or Rural | Route Nun | aber, City or Tow | n, State, Zi | p Code) | | _ |
| Committed of Disposition Chemister Committed C | Mr. Albert (| Genema | ns | | | | | | | | | | | | | |
| Columbia Mem. Pk. 9-8-94 Clarksville:, MD | 204 METHOD OF DISPOSIT | ION | | | PLACE | AND OATE | OF DISPO | SITION (N | | | | | | _ | wn, State | _ |
| 22. NAME AND ADDRESS OF FACILITY Slack Funeral Home, P. A. Ellicott City, MD 21043 23. PART Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, interval Batween Onsat failure. List only one cause on aech line. IMMEDIATE CAUSE (Finel diseases or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): 24b. WAS AN AUTOPSY PROPINGS AND AUTOPSY PROPINGS AN | | | oval from State | Cem | otery, cre | matory or of | Mem . | Pk | | 9_8 | R_94 | Cla | rker | rs-115 | ~ MD | |
| MO0535 Ellicott City, MD 21043 23. PART I. Enter tha diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on asch line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions. If any, leading to immediate cause. Enter MDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENC | 21. SIGNATURE OF FUNERA | LISERVICE LIC | ENSEE | | | | | . NAME A | ND ADDRES | SS OF FA | CILITY | | | 4 L L L | - PID | _ |
| 23. PART I. Enter the diseases, Dr complications that caused the death. Do not enter the mode of dying, such as cardiac Dr raspiratory arrest, above, or heart failure. List only one cause on aach line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause, enter UNDERLYING CAUSE (Olsease or injury that initiated evants reauting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUEN | * Colum | Alex | (| | M | 10053 | 5 | S1a E1 | ack F licot | unei t Ci | ral H itv. | Home, I | P.A. | | | |
| INMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQU | 23. PART I. Enter the di | seases, Dr c | omplications tha | t causad | tha de | ath. Do n | not anta | | | | | | | rest, | Approximata | |
| disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): 24a. WAS AN AUTOPSY PERFORMEDT 1 | | | List Dniy Dne cau | ise on as | ach Ilne | | | | | | | | 0, | | | |
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| H any, leading to immediate cause. Entar INDERLIVING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST DIE TO (OR AS A CONSEQUENCE OF): DIE TO (OR AS A | | | 302 10 | (on no n | 0011320 | Orner or | ·). | | | | | | | | | |
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| That initiated events reaulting in death LAST DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 26. PLACE OF DEATH (Check only one) TO THER: 1 Inpatient X FR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 1 Instrust 5 Pending Investigation 3 Suicide 8 Could not be 4 Homicide determined 28. DATE OF INJURY At home, farm, atreet, tactory, office 29. CERTIFIER (Check only one) 29. CERTIFIER (Check only one) 20. SIGNATURE AND TITLE OF CERTIFIER 29. SIGNATURE AND TITLE OF CERTIFIER 290. SIGNATURE AND TITLE OF CERTIFIER 290. LICENSE NUMBER 290. LICENSE NUMBER 290. LICENSE NUMBER 290. LICENSE NUMBER 290. DATE SIGNED (Month, De), Year) | | | | (| | | , | | | | | | | | ĺ | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY PERFORMED? 1 | | ry | DUE TO | (OR AS A | CONSEC | DUENCE OF | F): | | | | | | | | <u> </u> | - |
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| PERFORMED? AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO NO VEST | | | J | | | | | | | | | | | | - | - |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | PART II. Othar significa | nt condition | s contributing to | death be | ut not r | asulting i | in the u | nderlyin | g causa g | givan in | Part i. | | | 24b. | | |
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| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 26. PLACE OF DEATH (Check only one) 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 26. DATE OF INJURY 26. TIME OF WORK? 28. DATE OF INJURY 26. TIME OF Sealdence 6 Other (Specify) 29. Accident 5 Pending Investigation 2 26. DATE OF INJURY 2 2 2 2 2 2 2 2 3 3 | | | | | | | | | | | | | U.A. | | | |
| EXAMINER? 1 XYES 2 NO 1 Input ent X XER/Outpet ent 3 DOA 4 Numbing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Month, Day, Year) 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28c. INJURY AT WORK? 1 YES 2 NO 8 Could not be determined 28c. PLACE OF INJURY — At home, farm, street, tactory, office 4 Homicide 28c. PLACE OF INJURY — At home, farm, street, tactory, office 28c. LICENSE HOW INJURY — At home, farm, street, tactory, office 28c. LICENSE HOW INJURY — At home, farm, stre | DID TOBACCO U | SE CONTR | RIBUTE TO CA | USE O | F DEA | TH YE | s 🗆 | NO [| JUNC | ERTAII | N 🔲 | | | | | |
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| Natural S Pending Investigation S O O O O O O O O O | | | 1 Inpatient 2X | XER/Outpo | ntient 3 | □ DOA | | | ne 5 🗆 Re | aldence | 6 Oth | er (Specify) | | | | |
| Natural S Pending Investigation S / 6 / 94 1300 M 1 YES 2 NO BICYCLE STRUCK BY AUTO | 27. MANNER OF DEATH | | | | | | | | | | 28d. OE | SCRIBE HOW II | NJURY OC | CURED | | Ⅎ |
| 3 Suicide 4 Homicide 26. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) RORDWAY 29a. CERTIFIER (Check only one) 29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | | | 40. 2 | , | | | | | | NO | Ber | rie Son | . 10 11 | RVA | UTO | 1 |
| 4 Homicide determined CEVATY City or Town, State) HOWARD CEVATY STEVENS FOREST ROAD AND BROKEN LAND PARKED 29a. CERTIFIER (Check only one) 22 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the lime, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | 3 Sudelde | | 26e. PLACE O | F INJURY | — At ho | me, farm, a | street, to | ctory, offic | a | | 281. LO | CATION /Street a | nd Numbe | r or Rural 6 | Inche Alumber | 1 |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the lime, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | | | building, | etc. (Speci | rry) | | | | | | STEVE | or Town, State) | ROWA | AND QUE | WIY | |
| 22 XMEDICAL EXAMINER: On the basia of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | 29a. CERTIFIER 1 CERT | IFYING PHYSIC | CIAN: To the best of | | | | ed at the | time det | and stace | and do- | | | | | WHEN LINED FAIR | ä |
| 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | | | | | | |) and manner as stated. | |
| 11/2 11/4/11/11/11 | | | | - | | | | | _ | | | | | | | 4 |
| | Monald. | 4.U | night 1 | MD | | | | | | | | . | > | | | |

THY STULAN. THE IAW FEQUITES that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

The certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE FUNERAL TO THE FUNERAL DE NED WITHIN 728

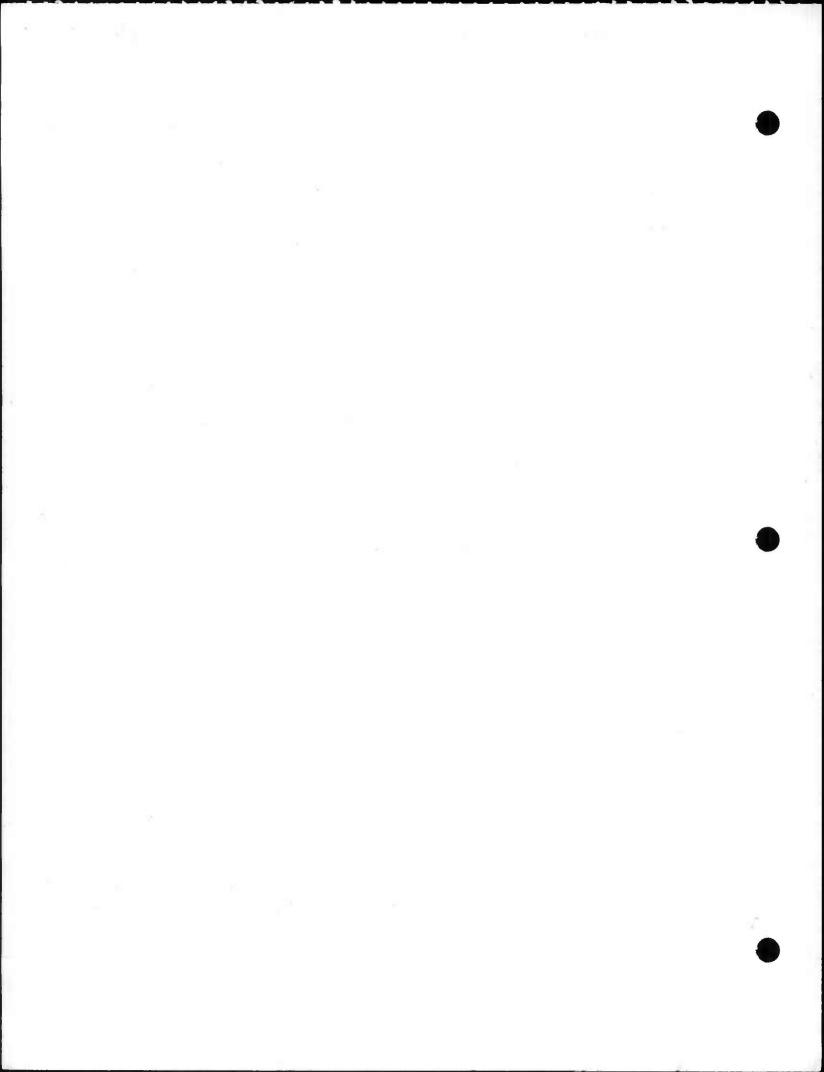
DONALD G. WRIGHT

31. DATE FILED (Month, Day, Year)

SEP 0 8 1994

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type. Print)

DONALD (2 4) DIELLE MAD 111 Penn Street, Baltimore, Maryland 21201



TO BE COMPLETED BY FUNERAL DIRECTOR

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| BALTIMORE, MARYLAND 21215-0020 | hours after death. Page 6 may be retained by the hospital or attending physician. | s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should thin the State Dept, of Health and Memal Hygiene prior to bunial, cremation, or removal. | medical examiner must be notified at once. | |
|---|---|---|--|--|
| DIVISION OF VITA". RECORDS, P.O. BOX 68760, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fibe within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |

| 1 - FOR STATE REGISTRAR | | STATE OF MARYL | | | ENT OF H | | | NTAL HYGIEN | | | | |
|---|--|--|-----------------|----------------|---------------------|---------------------|-------------|---|------------------|------------|---|--------|
| 1. DECEDENT'S NAME (First | , Middle, Last) | | | | | DEATT | - | . DATE OF DEATH | | 3. | TIME OF DEA | TH |
| Ronald | | | GRI | NAGE | | | s | eptember | 4, 199 | 4 3 | :00 | D M |
| 4. SOCIAL SECURITY NUME 215-42-03(| | l l | 'In yrs. last b | MON | UNDER 1 YEAR | IF UNDER 24 | HRS. 7 | DATE OF BIRTH (Month, Day, Year) | 8.1 | | CE (State or Fi | oreign |
| 90. FACILITY NAME (# not in | | Ø M 2 □ F | 51 | YRS. | | 2.3 | | 9-8-42 | | Ito. | Marv1 | and |
| Franklin | | | | 9b. | CITY, TOWN | OR LOCATION | OF DEAT | Н | 9c. COUNTY | | | |
| RESIDENCE OF DEC | EDENT | 1103p1ta1 | | | | | | | Balti | more | Count | |
| Maryland | 10b. COUNTY | timore | | 10c. CITY, TO | WH OR LOCA | TION | | | | 10d | I. INSIDE CITY | r |
| | Dal | Tillore | | | | | | | | 1 [| YES 2 | NO |
| 100. STREET AND NUMBER | soe Circ | 16 | | | 10: | ZIP CODE | 1220 | | 10g. CITIZEN | | | |
| 11. MARITAL STATUS | | 2. WAS DECEDENT EVER II | UII C ADME | · n | 40 400 054 | | | | | U.S. | | |
| 1 🔀 Never Married 2 🗌 | Company of the Compan | FORCES? 1 YES | 2 NO | :0 | If yes, sp | ecify Cuben, | Mexican, F | ORIGIN? (Specify Yes Puerto Rican, etc.) | | | Americen Indi nite, etc. | en, |
| 3 Widowed 4 Divo | rced | TES, OIVE WAR ON D | AICO | | 1 YES | 2 X NO | Specify: | | | Specify: | Black | |
| 15. DEC (Specify only | EDENT'S EDUCAT | TION mpleted) | (G/ve | kind of work | AL OCCUPATION | ON st of working | | 16b. KIND OF BUS | SINESS/INDUST | _ | | |
| Elementary/Secondary (0 | -12) | College (t-4 or 5+) | lite. De | NOT use reti | k Driv | | | 1 | | | | |
| 17. FATHER'S NAME (First, M | iririlo (aet) | | | Truc | אווע א | | | | | | | |
| | njamin (| Grinage | | | | 16. MOTHE | R'S NAME | Vera Sec | lawick | | | |
| 19e. INFORMANT'S NAME (7) | | | 19b. I | MAILINO ADD | PRESS (Street e | nd Number or | Rumi Rout | te Number, City or Tow | | fel | | |
| Re | gina E. | Bryant | 1 | .00 Ai | ken Ci | rcle | Bal | timore, I | Marylar | d | | |
| 20a, METHOD OF DISPOSITI | | | | | SPOSITION (NE | | | DATE 20c. LO | CATION — City | or Town, ! | State | |
| 4 Donation 5 Other | (Specify) | | Garri | <i>Son"F</i> | orest | | | | ings Mi | lls, | Md. | |
| 21. SIGNATURE OF FUNERAL | L SERVICE LICEN | 944 | | | 22. NAME A | D ADDRESS | OF FACILI | ™ Willian | n C. Br | own | Commui | nitv |
| May le | 111. | 1 Por | 401 | 0 | F.H. | 1206 | W. N | orth Ave. | | | | 1217 |
| 23. PART I. Enter the di | seeses, or con | nglications that ceused only one cause on e | the deet | h. Do not e | nter the mo | de of dylng | , such s | s cerdiec or respi | ratory arrest, | | Approxim | |
| IMMEDIATE CAUSE (Fin | - | t only one cause on e | ecn line. | | | | | | | į | Onset sno | |
| disesse or condition resulting in death) | → | Pneumonia | | | | | 2we | eks | | | | |
| | | DUE TO (OR AS A | CONSEQUE | ENCE OF): | | | | | | | | |
| Sequentielly list conditi | Dille, | Hodgkins di | sease | ENCE OF | | | 3mc | nths | | | | |
| If sny, leeding to immed cause. Enter UNDERLYI | NG | 202 10 (0.11.20) | CONSCOS | LIVEL OF J. | | | | | | i | | |
| CAUSE (Disease or Inju- that initieted events | ry C. | DUE TO (OR AS A | CONSEQUE | ENCE OF): | | | | | | | | |
| resulting in deeth) LAS | T d | | | | | | | | | | | |
| PART II. Other significe | nt conditions c | ontributing to deeth h | ut not resu | ulting in th | e underlular | a course of | on In Day | t I. 24s. WAS AN | истором Т | 1 | IE AUTOPSY FI | |
| arterioscle | | | | | | j ceuse giv | on m rer | PERFOR | | AVAI | IL AUTOPSY FI LABLE PRIOR IPLETION OF (| то |
| myocardial | | | | | | | | 1 TYES 2 | □ NO | OF E | DEATH? | |
| | | SUTE TO CAUSE O | E DEATH | YES [| T NO F | LINCE | RTAIN | | İ | 1 [| YES 2 🗌 I | 10 |
| 25. WAS CASE REFERRED TO | MEDICAL | | | | heck only one) | OIACEI | VIAII 1 | | | | _ | |
| EXAMINER? | | OSPITAL: | atient 3 🗆 | | HER: Nursing Hom | e 5 🗆 Resid | lence 8 | Other (Specify) | | | | |
| 27. MANNER OF DEATH | | 28e. DATE OF INJURY (Month, Day, Year) | 2 | 8b. TIME OF | 28c. INJ | URY AT | 28 | d. DEŞCRIBE HOW II | NJURY OCCURE | D | | |
| | Pending nveatigation | | | | M 1 🗆 1 | 'ES 2 🗌 N | 10 | | | | | |
| | Could not be | 28e. PLACE OF INJURY building, etc. (Spec | — At home. | , ferm, street | , tactory, office | | 28 | f. LOCATION (Street a City or Town, State) | nd Number or R | ural Route | Number, | |
| | | | | _ | | | | | | | | |
| (Check only | | N: To the best of my knowl | | | | | | | | | | |
| | | On the basis of examination | end/or Inve | atigation, in | my opinion, d | esth occured | at the time | e, date end place, en | d due to the cer | rse(e) end | menner ee si | lated. |
| 29b. SIGNATURE AND TITLE | OF CERTIFIER | * | | | | 29c. LICENS | | | 29d. DATE SIG | NED (Mon | th, Day, Year) | |
| 30. NAME AND ADDRESS OF | DEBSON WHO O | OMBI ETED CAUSE OF THE | 111 | 7 | | 77 | 396 | 0 | 1/1 | 4/9 | 4 | |
| | | | | | | D 1 | 201 | 01007 | | | | |
| 31. DATE FILED (Month, Day,) | | 9000 Frank | in So | juare | Dr. | Balto. | Md. | 21237 | | | | |
| SEP 0 | 8 1994 | White was an analysis | | ~1 | | | | | | | | |

The second of the second

| BALLIMORE, MANILAND 21213-0020 | ath. Page 6 may be retained by the hospital or attending physician. | certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should |
|---|---|---|
| _ | fours after d | led in by the |
| CHICAGO OF ALIAE AECOADS, T.O. BOX 60100, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Flours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled |

| _ | | FOR 1 - STATE REGISTRAR | STATE OF N | ARYLAND | / DEPAR | TMENT OF I | HEALTH AND | MENTAL HYGIEN | | | | |
|--|--|--|------------------------------|---------------------|----------------|-------------------------------|---------------------------------------|---|--------------------|--|--|--|
| | | 1. DECEOENT'S NAME (First, Middle, Last) | 7.37 | | | | | 2. DATE OF DEATH C | 2-94 | 3. TIME OF DEATH | | |
| | | MARY FRANCES GF | | | | | · · · · · · · · · · · · · · · · · · · | 09 0 | | 14 COPM | | |
| | | 577 14 0800 | 5. SEX 1 | 6. AGE (In yrs. 7 7 | | #F UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN, | 7. DATE OF BIRTH (Month, Day, Year) 3 - 21 - 17 | | BIRTHPLACE (State or Foreign Country) Wash. DC | | |
| | | 9a. FACILITY NAME (If not institution, give s | treet end number) | | | 9b. CITY, TOWN | OR LOCATION OF D | | | Y OF OEATH | | |
| | TOR | Stella Maris | Nursin | g Hom | е | Т | owson | | Balt | imore County | | |
| | DIRECTOR | Maryland Balt | imore Co |) | | wings | | - | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | |
| | AL. | 10e. STREET AND NUMBER | | | | | f. ZIP CODE | | 40. 017177 | | | |
| - 11 | | | Mill Roa | | | | | 117 | , | N OF WHAT COUNTRY? USA | | |
| | E CN | 11. MARITAL STATUS | 12, WAS DECEDEN FORCES? 1 | | | | | NIC ORIGIN? (Specify Ye | e or No- 14 | Black, White, etc. | | |
| | E R | 1 Never Married 2 Married 3 Wildowed 4 W Divorced | IF YES, GIVE W | | No | | 3 2 NO Speci | en, Puerto Rican, etc.) fy: | | Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4 or 5 +) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | STRY | | | |
| | 로 12+ '4 Bookkeeper | | | | | | | | | | | |
| ou c | 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | | | | | |
| at a | william O'Connor Ann | | | | | | | | | | | |
| 196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stelle, Zip Code) 13.0.3.6. Rosawor, Dom, Pd. Cook ownered to M.D. | | | | | | | | | | | | |
| Bill Gray 13036 Beaver Dam Rd, Cockeysville | | | | | | | | 11e,MD21030 | | | | |
| must b | | 20e, METHOD OF DISPOSITION 1 | oval from State | | CEAND DATE O | OF DISPOSITION (Nather place) | ame of | OATE 20c. LC | CATION — CIT | y or Town, State | | |
| 5 | | 21. BIGNATURE OF FUNERAL SERVICE LIC | ENGLIR O'D'AI | d Wad | e,Dir | 22. NAME A | NO ADDRESS OF F | CILITY State | Anat | omy Board | | |
| or removal. medical examiner must | J | 655W.Baltimore St,Balto,MD21201 | | | | | | | | | | |
| removal | 7 | 23 PART I. Enter the diseesea, or o | complications that | caused the | deeth. Do r | not enter the me | ode of dying, suc | ch as cerdiac or reep | iratory erres | t, Approximete | | |
| | 4 | shock, or heert fellure. | List only one ceu | se on eech i | ine. | | | | | Interval Between Onset and Death | | |
| the the | | IMMEDIATE CAUSE (Finel disease or condition | COL | ON1 C | 1 A-AI | CER | | | | Onset and Death | | |
| event, the | ı | reaulting in death) | e. OUF TO | OR AS A CON | 1 | | | | | ogus. | | |
| - du | _ | _ | 502 10 | (On AS A CON | SECUENCE OF | r). | | | | 0 | | |
| traumatic | HILICATION | Sequentially list conditions, | DUE TO | OR AS A CON | SEQUENCE OF | n: | | | | | | |
| rau i | 4 | If any, leading to immediate cause. Enter UNDERLYING | | (0.1.1.0.1.001. | | 7- | | | | | | |
| jury, or other trace | 를 | CAUSE (Disease or Injury that initiated evente | OUE TO | OR AS A CON | SEQUENCE OF | F): | | | | | | |
| or other | ≣ ዘ | reaulting in deeth) LAST | | | | , | | | | | | |
| lury, o | <u>.</u> | | d | | | | | | | + | | |
| any in | PART II. Other significent conditions contributing to deeth but not reaulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMEO? AMILIABLE PRIOR TO COMPLETION OF CAUSE | | | | | | | | AVAILABLE PRIOR TO | | | |
| shows | Ž. | DID TOBACCO USE | CNITPIRIITE | TO CA | LISE OF | DEATH Y | ES TINO | X | / | 1 YES 2 NO | | |
| 13 Jep | AN I | 25. WAS CASE REFERRED TO MEDICAL | CONTRIBUTE | IO CA | OSE OF | | | / | | | | |
| State | 2 | EXAMINER? | HOSPITAL: | ER/Outpatient | 3 🗆 DOA | OTHER: | LACE OF DEATH (C) | Other (Specify) | Hospid | ce | | |
| ē • 2 | | 27. MANNER OF DEATH | 26a. DATE OF | INJURY | 28b. TIM | E OF 28c, IN | IURY AT | 28d. OEŞCRIBE HOW | | | | |
| > 36 | Action 1 S Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO | | | | | | | | | | | |
| 1 28 at | 3 Suicide 8 Could not be determined 28. Could not be determined 28. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| I ite | 1 13 | | | | | | | e to the cause(e) end ma e time, data and place, e | | cause(a) end menner as stated. | | |
| PORTANT: | ا د | 20. SIGNATURE AND TITLE OF CERTIFIER | | | - | | 29c. LICENSE NU | | | SIGNED (Month, Day, Year) | | |
| IMPORTANT: | | Kendall Rf | aule | nem | | | Das | _ | ▶ 9/ | 72/94 | | |
| F | - 1 | 30. NAME AND ADDRESS OF PERSON WH | COMPLETED CAUS | E OF OEATH (| TEM 27) (Type, | Print) | | | | | | |

Dr Kendall Faulkner, MD 2300 Dulaney Valley Rd., Towson, MD

31. DATE FILED (Month, Day, Year)

SEP _ 8 1994

July Structure

SEP _ 8 1994

the hospital or attending physician. retained by death. Page 6 may be

BALTIMORE, MARYLAND 21215-0020

funeral director, filled in by the requires that the death certificate be N. The **INDING PHYSICIAN:**

MSION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO 1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATN 3. TIME OF DEATN ALAC 10 9 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTN (Month, Day, Year) 5. SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign 1 M 2 216-05-8421 Jan. Maryland 9a. FACILITY NAME (If not institution, give street and no 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Pages 1, 2, 3 Northwest Hospital Center <u>Baltimore</u> Randallstown 10b, COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Randallstown 1 TES 2 DONO Baltimore permit. FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? use as the burial-transit 5412 Old Court Road 21133 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 FORCES IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 Tes 2 Tyo Specify BY 3 Widowed 4 □ Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) page 5 should be detached for U.S.F & G. Accountant 10th 17. FATHER'S NAME (First Middle Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Annie E. (Gates) ä BE James L. Amos notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Jean McGuinness 7308 Dooman Road Baltimore Md. Pe 20s. METNOD OF DISPOSITION

1 DBurlal 2 Cremetion 3 Ramoval from State
4 Donation 5 Other (Second) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata DATE must Donation 5 - Other (Specify) . Loudon Park Cemetery ' Sept 6.1994 Baltimore Md examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Loring Byers 8728 Liberty Rd. Randallstown medical 23. PARY I. Enter the diseases, or compilections that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. intarvai Between 6 IMMEDIATE CAUSE (Final **Onset and Death** the NEYMONIA disesse or condition n and completely file to burial, cremation resulting in death) event. DUE TO (OR AS A CONSEQUENCE OF) C129= traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 been signed by the attending physician of Health and Mental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AMAILABLE PRIOR TO any COMPLETION DF CAUSE 1 YES 2 NO DE DEATH? Shows 1 YES 2 NO s certificate has been the State Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) EXAMINER? HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER: 4 ☐ Nursing Home 5 ☐ Rasidenca 6 ☐ Other (Specify) 0 27. MANNER DE DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 28b. TIME OF this c marked. 1 Natural 5 Pending Investigation 1 YES 2 NO After t BY 2 Accident 26a. PLACE OF INJURY — building, etc. (Specify) Al homa, farm, straet, factory, offica 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2 6 Could not be COMPLETED 22 4 Homicide 29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the bests of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as steted. TO THE HOPPI TO THE FUNES De Shed within 29b, SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 9

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year) SEP 0 8 1994

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2. REGISTRAR'S SIGNATURE

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| OF VI | NG PHYSICIAN: The law requires that the death ce |
| DIVISION OF VITAL I | DSPITAL OR ATTENDING |
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29b. SIGNATURE AND TITLE OF CERTIFIER

31. DATE FILED (Month, Day, Year)
SFP 8 1994

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH HELEN KATHLEEN SEP 1155Am 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8 BIRTHPI ACE (State 213-34-5454 55 HOURS 1 M 2 T YRS. permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH NORTHWEST HOSPITAL CENTER DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 YES 2 NO FUNERAL STREET_AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 36 been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit or. of Health and Mental Hygiene prior to burial, cremation, or removal. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO 1F YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-RACE - American Indian, Black, White, atc. If yes, specify Cuben, Mexican, Puerto Rican, etc.) BY YES 2 NO Specify: Specify: I 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 184. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during life. Do NOT use retired.) College (1-4 or 5+) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at BE 19a. INFORMANT'S NAME (Type/Print) 2 must be 20a. METHOD OF DISPOSITION 20b. PLACEAND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town. State DATE 2 Cremet 4 Donation 5 Other the medical examiner 22. NAME AND ADDRESS OF FACILITY ma ode.Di BOUNT 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Finel **Onset and Death** CELL CA OF CUNG disease or condition QUAMOUS resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentielly liet conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury shows any injury, or other DUE TO (OR AS A CONSEQUENCE OF): thet initieted events reaulting in death) LAST PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. WAS AN AUTOPSY PERFORMED? MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 00 OF DEATH? 1 - YES 2 - 100 PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES the State Dept. Item 23 TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law TO THE FUNERAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State DeprIMPORTANT: If Item 28 Is marked, or Item 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Conpetient 2 ER/Outpetient 3 DOA OTHER: 1 TES 2 TO NO 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28a. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending ВУ 1 YES 2 NO 2 Accident Investigation 3 Sulcide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated 2 MEDICAL EXAMINER:

exemination and/or investigation, in my opinion, death occured at the time,

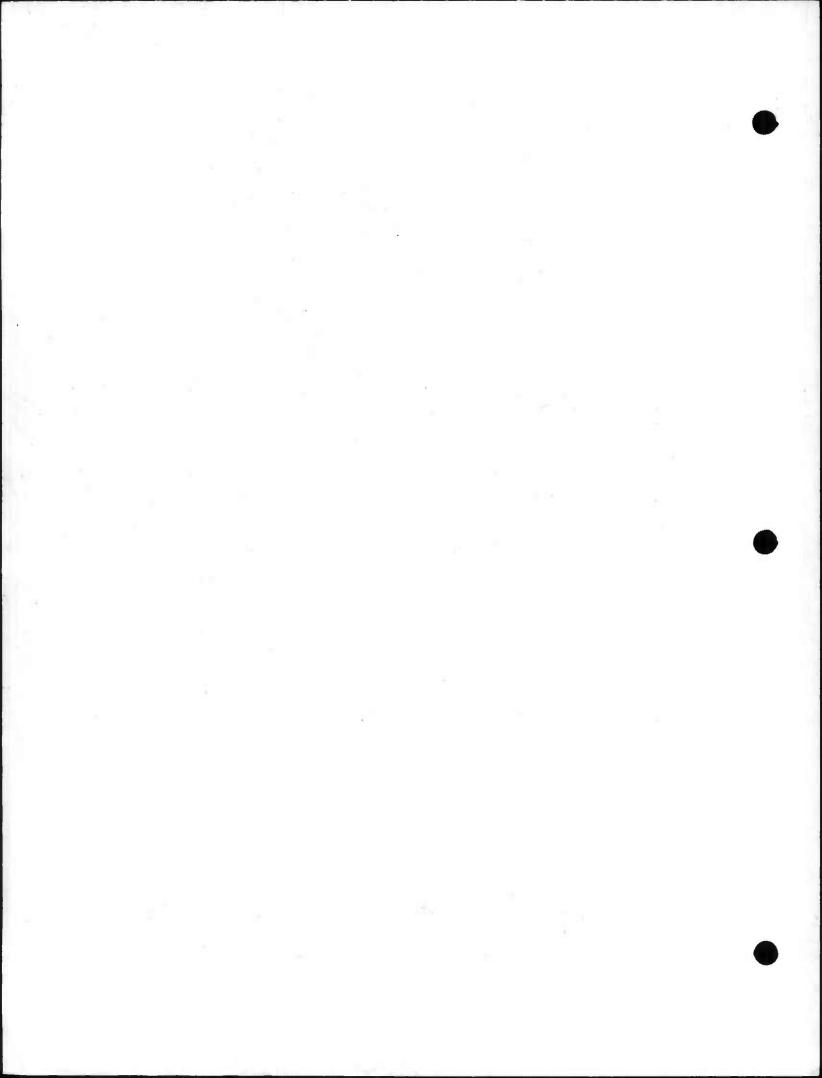
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32. PEGISTRAR'S SIGNATURE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VI

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year)



death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 should

permit.

use as the burial-transit

ISION OF VITAL RECORDS, P.O. BOX 68760, ENDING PHYSICIAN: The law

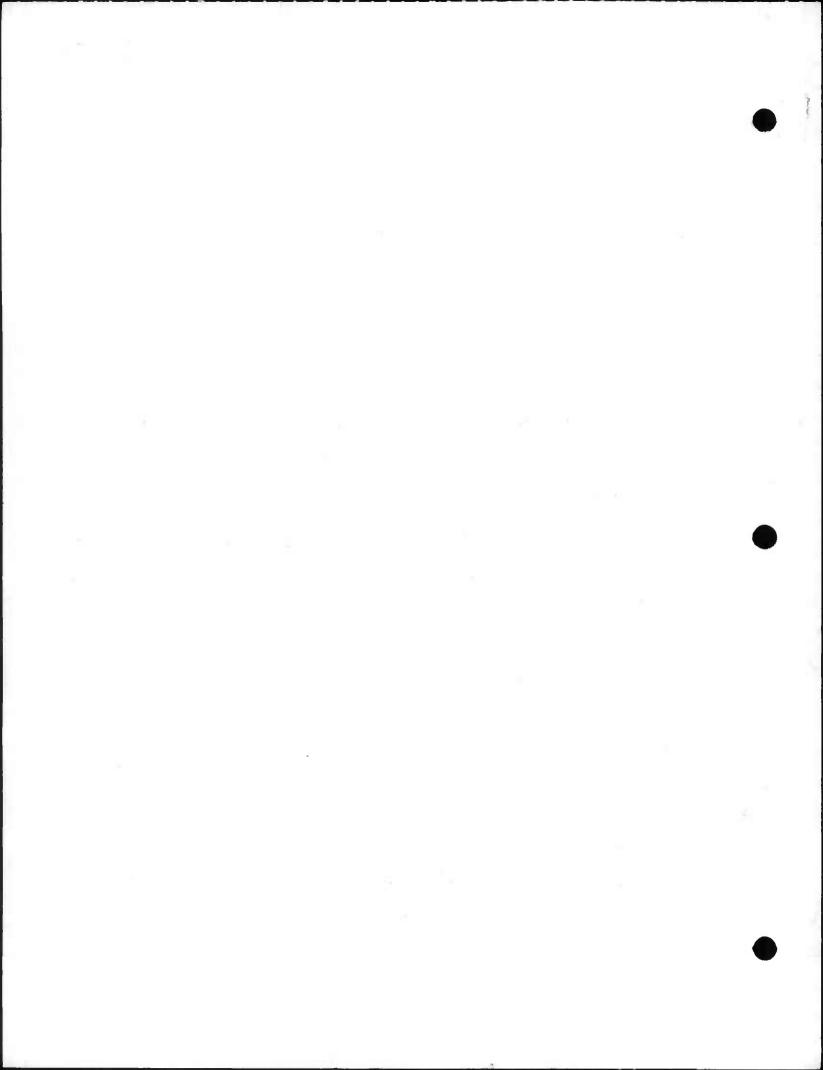
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| | in perificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached | the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | and or Hom 22 chouse any injury or other fraumotic awant the modified avantage much be modified as much |
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reb STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH PAULINE WINONA HOFFMAN Sept.6, 1994 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. Jan. 30, 218-26-7648 DAYS HOURS 1 M 27/7/2F 64 1930 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN DR LOCATION OF DEATH 9c. COUNTY OF DEATH RECTOR 3214 Boones Lane Ellicott City Howard County RESIDENCE OF DECEDENT 10a. STATE 10b. CDUNTY 10c. CITY, TOWN DR LOCATION 10d. INSIDE CITY ō Maryland Howard County Ellicott City 1 YES 2 WO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN DF WHAT COUNTRY? 3214 Boones Lane 21042 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT DF HISPANIC DRIGIN? (Specify Yee or Noif yee, specify Cuben, Mexicen, Puerto Rican, etc.)
1 YES 2 ND Specify: 14. RACE — American Indian, Black, White, etc. t Never Merried 2 Merried В Specify: white 3 Widowed 4 Divorced COMPLETED 18e. DECEDENT'S USUAL OCCUPATION

'Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b, KIND OF BUSINESS/INDUSTRY (Specify only highe (Give kind of work done life. Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5+) 12th Homemaker own home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surne Roy James Brandenburg adie Frances Linder BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. John Hoffman, Sr. 3214 Boones Lane, Ellicott City, MD 21042 20a, METHOD OF DISPOSITION
1 N Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Lakeview Memorial Park Sept 9 / 94 4 Donetion 5 Other (Specify) Eldersburg, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Slack Funeral Home, P.A. Ellicott City, Maryland 21043 M00535 23. PRT I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. Approximate interval Between IMMEDIATE CAUSE (Final Onset and Death Acute Mycardial infarction disease or condition resulting in death) mil DUE TO (DR AS A CONSEQUENCE DE): Atheroscientic Cardiovanular discuse yns CERTIFICATION Sequentially list conditions, DUE TO (DR AS A CONSEDUENCE DF): If any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (DR AS A CONSEQUENCE OF): that initiated eventa reauiting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS MEDICAL 24a, WAS AN AUTOPSY Cirarelle abore COMPLETION OF CAUSE 1 | YES 2 | YO DF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES X NO UNCERTAIN U PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE DF DEATH (Check only one) EXAMINER? OTHER: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 28e. DATE DF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Matural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, lerm, atreet, lectory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Paral Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide determined 1 _ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(e) end menner ee stated. EDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the ilms, date and place, end due to the ceuse(e) end menner es stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER Depluty 29d. DATE SIGNED (Month, Day, Year) BE 314 c. Ms 9-6-91 Horand 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print PATMICE A-TOLE, MO 4565 HEMLICKCINE WAY BLUICHT CITY MD 21042 31. DATE FILED (Month, Day, Year)
SEP U 8 1994 32. REGISTRAR'S SIGNATURE in Dendem-Rudowl



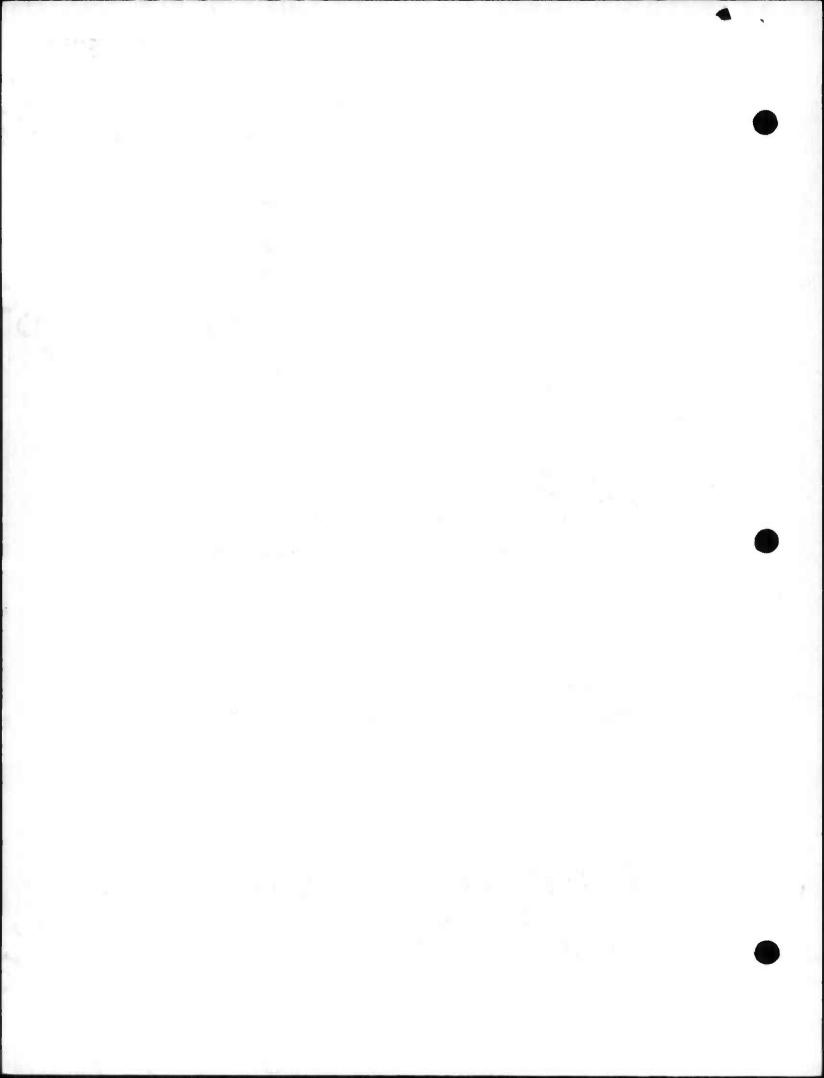
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and recommend of the completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

FOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| | 1 - STATE REGISTRAR | | CE | RTIF | | | DEATH | | | EG. NO | _ | | | | |
|---------------|---|------------------------------|--|-------------|--|-------------------|----------------|-----------------------------------|---|------------------------|----------------------|----------------------------------|-----------------------|-------------------------|-------|
| | 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE (| | | | | | | | | ATE OF DEATH | | | YEAR 3. TIME OF DEATH | | |
| | JOHN W. HALL, SR. | | | | | | | | Senten | ber | 6. | 1994 | | 1 20 | MH |
| | | | B. AGE (In yrs. last | birthday) | IF UNDER 1 | YEAR DAYS | IF UNDER 24 H | HRS. | 7. DATE OF I | BIFITN N. Magri | | 8, BIRTI | | (State or For | reign |
| | 417 03 1133 | 1 XM 2 - F | 75 | YRS. | | UNITE S | MOONS III | "". I | DEC. 2 | 23, | 1918 | VIF | RGIN | IA | |
| E | 9a. FACILITY NAME (if not institution, give street and number) LAUREL REGIONAL HOSPITAL | | | | 96. CITY, TOWN OR LOCATION OF D | | | OF DEA | EATH 9 | | | c. COUNTY OF DEATH PRINCE GEORGE | | | |
| 6 | RESIDENCE OF DECEDENT | SELIAL | | | L | LA | UKEL | | | | Pr | CINCE | GE | URGE | |
| DIRECTOR | 10a. STATE 10b. COUNTY | | | 10c. CIT | Y, TOWN OR | LOCAT | ION | | | | | | 10d. (N | ISIDE CITY | |
| | MARYLAND PRINCE GEORGE | | | LAUREL | | | | | 1 X YES 2 NO | | | | | | |
| ¥ | 10e. STREET AND NUMBER | | | | 101. ZIP CODE | | | | | TIZEN OF WHAT COUNTRY? | | | | | |
| FUNERAL | 119 IRVING STREET | | | | 20707 | | | | Ū | | | USA | | | |
| 5 | | EVER IN U.S. ARI | | | WAS DECENDENT OF HISPAN If yea, specify Cuban, Maxica | | | | or No- | 14. RAC | E — Ame k, White, | elc India | n, | | |
| В | 1 Never Married 2 X Married IF YES, GIVE WARFOR 1944-1945 | | | | | | | Specify: | | | | | Specify: WHITE | | |
| | 15. DECEDENT'S EDUCAT (Specify only highest grade co | 18a. DE | Ba. DECEDENT'S USUAL OCCUPATION 16b. | | | | | 16b. KIN | ID OF BU | SINESS/IN | DUSTRY | | - | | |
| Ē | | College (1-4 or 5+) | life. | Do NOT u | | ring mo: | st of working | | | | | | | | |
| P P | 7 | Ø | MEC | CHANI | .C | | | | RI | EPAII | ? | | | | |
| COMPLETED | 17. FATNER'S NAME (First, Middle, Last) | | | | | | | | E (First, Middle | | | | | | |
| BE (| ELLIS C. HALL, SR. | | | | | | MINN. | IE 1 | R. FIT | rzge! | RALD | | | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) THELMA M. HALL | | | | | | nd Number or I | | | | | | 707 | | |
| | | | _ | | | | REET, | LA | UKEL, | MAK. | LANL | 207 | 07 | | |
| | 20a. METNOD OF DISPOSITION 1 ▼ Burlel 2 □ Cremation 3 □ Ramovi | al from State | 20b, PLACE A cemetery, crer | natory or o | ther placel | | | | DATE 20c. LOCATION City or Town, Stata | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | annie. | FT. LI | NCOL | | | | | | | | | | RYLAN | |
| | ZI. SIGNAL ONE OF POWERAL SENTEELLES | 1 | - // | | | | O ADDRESS | | I. I | | | | | E, IN | |
| | (/alaoox | 1. VOA | Orai | | | | SANDY | | | | | - | MD | 2070 |)7 |
| | 23. PART i Enter the diseases, ar cor shock, or heart fellure. Lis | iplications that | caused the de | th. Do i | not enter th | е то | de of dying, | such | aa cardiac | or reap | iratory ar | rest, | | pproxima | |
| , | IMMEDIATE CAUSE (Finel | it only one way | and back mist |) | | | | | | | | | | nterval Be Inset and | |
| ľ | diseese or condition resulting in death) | Car | unon | ma. | Do | Th | Da | ME | Ams | | | | | 1,00 | 60 |
| | | DUE TO (| OR AS A CONSEC | UENCE O | F): | | Pico | | | | | - | 1 | | (-7 |
| Z | Sequentielly list conditions, b. | | | | | | | | | | | | | | |
| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (| OR AS A CONSEC | UENCE O | F): | | | | | | | | | | |
| 5 | CAUSE (Disease or Injury C. | DUE TO / | OR AS A CONSEC | UENCE O | - | | | | | | | | | | |
| | thet initiated events resulting in death) LAST | DOE 10 (0 | OR AS A CONSEC | DENCE O | r): | | | | | | | | i | | |
| E | d | | | - | | | | | | | | | + | | |
| A. | PART II. Other significent conditions | contributing to d | deeth but not re | esuiting | In the unde | erlying | cause give | n in P | art I. 24 | . WAS AN | AUTOPSY | 24b | | UTOPSY FIN | |
| DICAL | Careinomo | JOJ T | Le P | 205 | Tate | | | | _ 10 | YES 2 | | | | ETION OF C | |
| ME | | 0 | 1 | | | | | | | | | | | ES 2 N | 0 |
| ä | DID TOBACCO USE CO | ONTRIBUTE | TO CAUS | SE OF | DEAT | H Y | ES 🔲 | NO | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | IOODIT: | | | | 28. PL | ACE OF DEAT | N (Chec | k only one) | | | | | | |
| S | | HOSPITAL: | ER/Outpatient 3 | □ DOA | OTHER: | g Hom | e 5 🗆 Reside | enca 8 | Other (Sp | recify) | | | | | |
| ξI | 27. MANNER OF DEATN | 28a. DATE OF II | NJURY (Year) | 28b. TIM | | | URY AT | 1 | 28d. DESCRI | BE NOW I | NJURY OC | CUREO | | | |
| BY | 1 Natural 5 Pending 2 Accident investigation | (, 5.5) | | | | - | ES 2 N | 0 | | | | | | | |
| | 3 Suicide 8 Could not be | 28a. PLACE OF building, a | 28a. PLACE OF INJURY — At home, term, street, building, atc. (Specify) | | | , factory, office | | | 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| | 4 Nomicide determined | | | | | | | | ony or no | wit, Otoloy | | | | | |
| 7 | 290. CERTIFIER 1 CERTIFYING PHYSICIA | AN: To the best of n | ny knowledga, dea | th occum | ed at the time | e, date | and pleca, and | d due to | the cause(s |) and mar | nner as sta | ted. | | | |
| COMPLETED | The Certifier (Check only one) Check only one) MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | |
| | 710 // | | | | | | | | E SIGNED | (Month. | Day Year) | 100 | | | |
| BE | MINETE THE | | | | | | DO | 29d. DATE SIGNED (Month, Day, Yea | | | | | 6.16 | 194 | |
| 유 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE | E OF DEATH (ITEM | 1 27) (Type | , Print) | | 110 | 00 | | | | MOU | Alla | 0/17 | 1/ |
| | BRUCE U. GATTIS 8383 CHERRY LANE, LAUREL, MD 20707 | | | | | | | | | | | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR | S SIGNATURE | , | | | | | | _ | | | | | |
| | SEP 0 8 1994 A | THE DEPOSIT | PENT . B. / MALCAPIN | ¥ | | | | | | | | | | | |



REG. NO.

1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH Beatrice 06 :30 PM ranlet 139 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 217-14-95 1 M 2 - F North Carolina 07-01permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Sinai Haspital Balkmore DIRECTOR Baltimere DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Baltimore Baltimore 1 YES 2 NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3612 Latham Rd. retained by the hospital or attending physician. 5 should be detached for use as the burial-transit 21207 USA 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, OIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No- RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 X Married It yes, specify Cuban, Maxican, Puerto Rican, etc.)

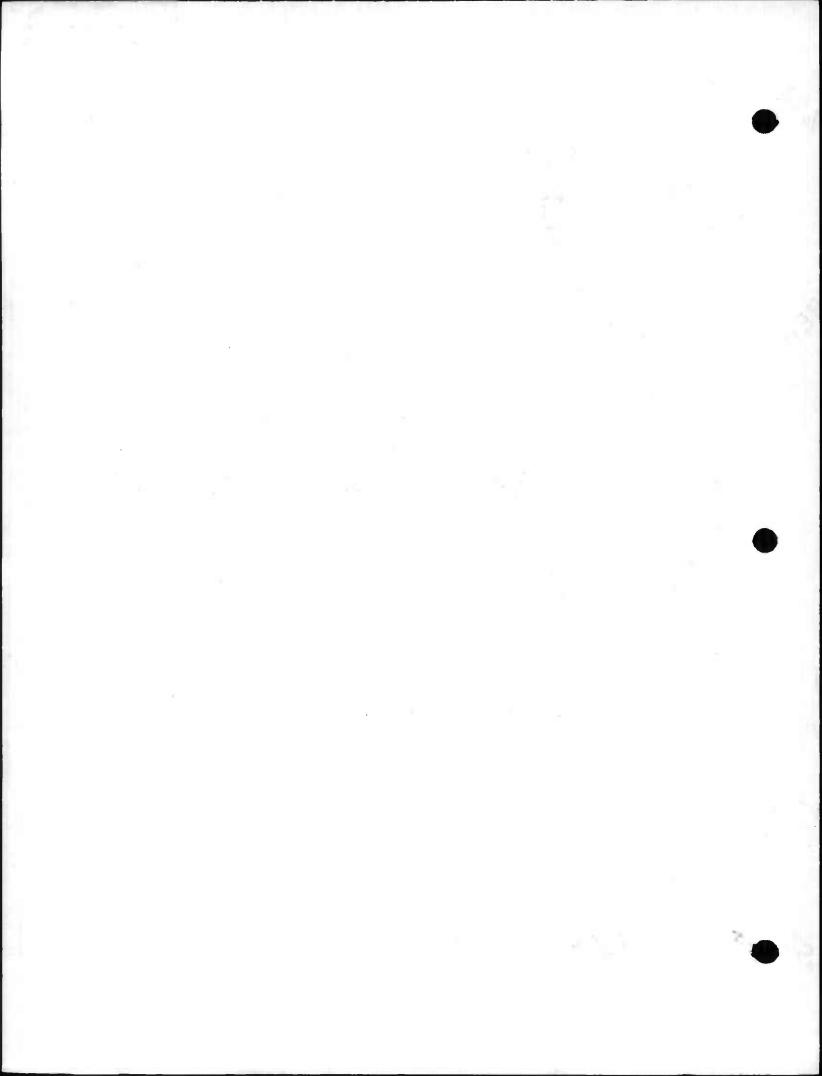
1 YES 2 NO Specify: B^{\vee} 3 Widowed 4 Divorced Specify: Black COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify College (1-4 or 5+) Longshoreman Maryland Port Authority once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Embra Hamlett Caroline Hamlett F BE page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Jerusha Hamlett 3612 Latham Rd. Balto., Md. 21207 ours after death. Page 6 may be pe METHOD OF DISPOSITION

Burlel 2 Cremation 3 Removal from State 20c. LOCATION - City or Town, State must t 20b. PLACE AND DATE OF DISPOSITION (Name of DATE funeral director. Woodlawn Cemetery 9-10Woodlawn Maryland 4 Donation 5 Other (Specify). 21. SIGNATURE OF FUNERAL SERVICE LICENSES examiner 22. NAME AND ADDRESS OF FACILITY Derrick C. Jones F.H. 1)eruc/C 4611 Park Heights Ave. Balto., Md.15 filled in by the foot, or removal. medical 23. PART t. Enter the diseases, or complicatione that caused the death. Do not enter the mode of dying, such se cerdisc or respiretory errest, Approximata ahock, or heart fellure. List only one cause on each line. Interval Between 50 IMMEDIATE CAUSE (Final Onset and Death traumatic event, the cremation. disease or condition resulting in death) Preumonia completely DIVISION OF VITAL RECORDS, P.O. BOX 68760 executed wit DUE TO (OR AS A CONSEQUENCE OF): burial, MUMPLE EMBOLIC CY DUE TO (OR AS A CONSEQUENCE OF): . CVA with craphologathy CERTIFICATION and Sequentially list conditions, 10 If any, leading to immediate cause. Enter UNDERLYING physician HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be Mental Hygiene prior CAS6 CAUSE (Diseese or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST affending 0 Injury. signed by the a Health and Men PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO any COMPLETION OF CAUSE OF DEATH? shows a 1 YES 2 NO 10 PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO [Dept. s certificate has the the State Dept 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem 1 YES 2 NO HOSPITAL:
1 Anpatient 2 ER/Outpatient 3 DOA OTHER: 6 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) this c 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked. 1 Natural 5 Pending Investigation DIRECTOR: After the hours after death vitem 28 is mark 1 YES ΒY 2 NO 2 Accident 28e. PLACE DF INJURY — At home, ferm, street, tectory, office building, etc. (Specify) 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILED WITHIN 72 h 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Drain 9848 Diane ASZYOZJZI DT 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 26 Baltmer Sihon Hospital 62 REGISTRAR'S SIGNATORE 31. DATE FILED (Month, Day, Year) SEP 0 8 1994

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

FOR STATE REGISTRAR

DHMH-16 Rav 1/89

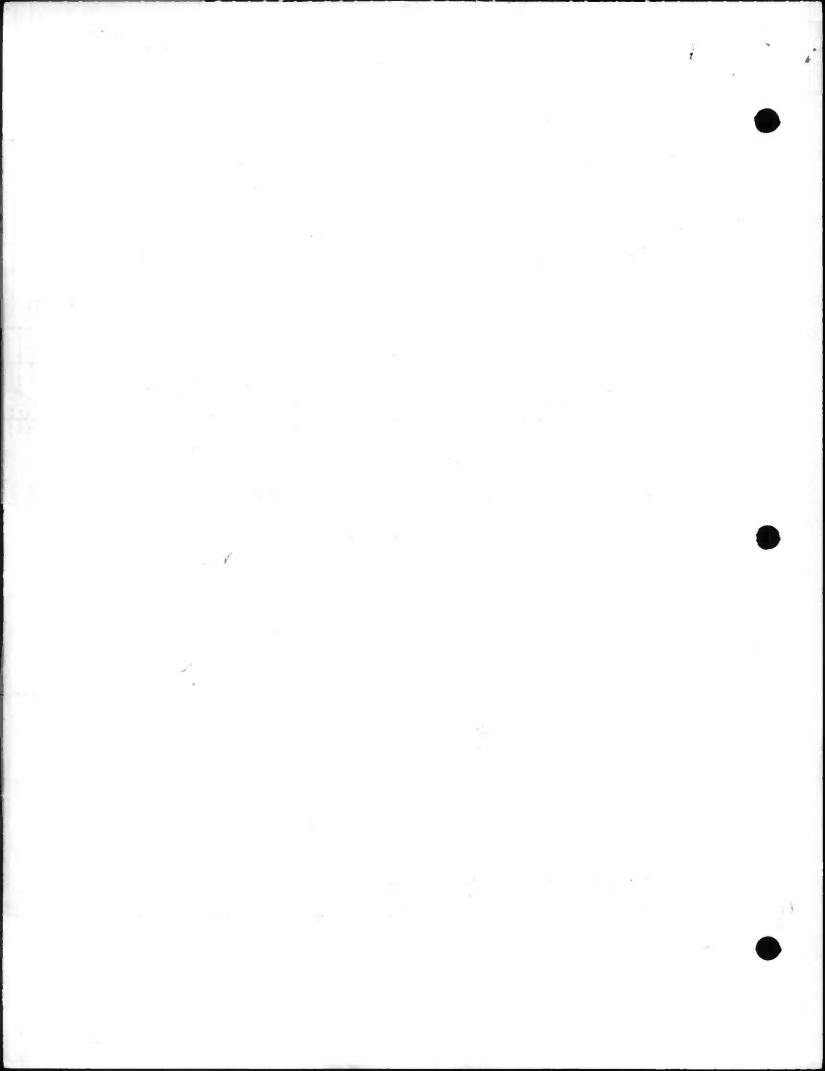


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 54 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

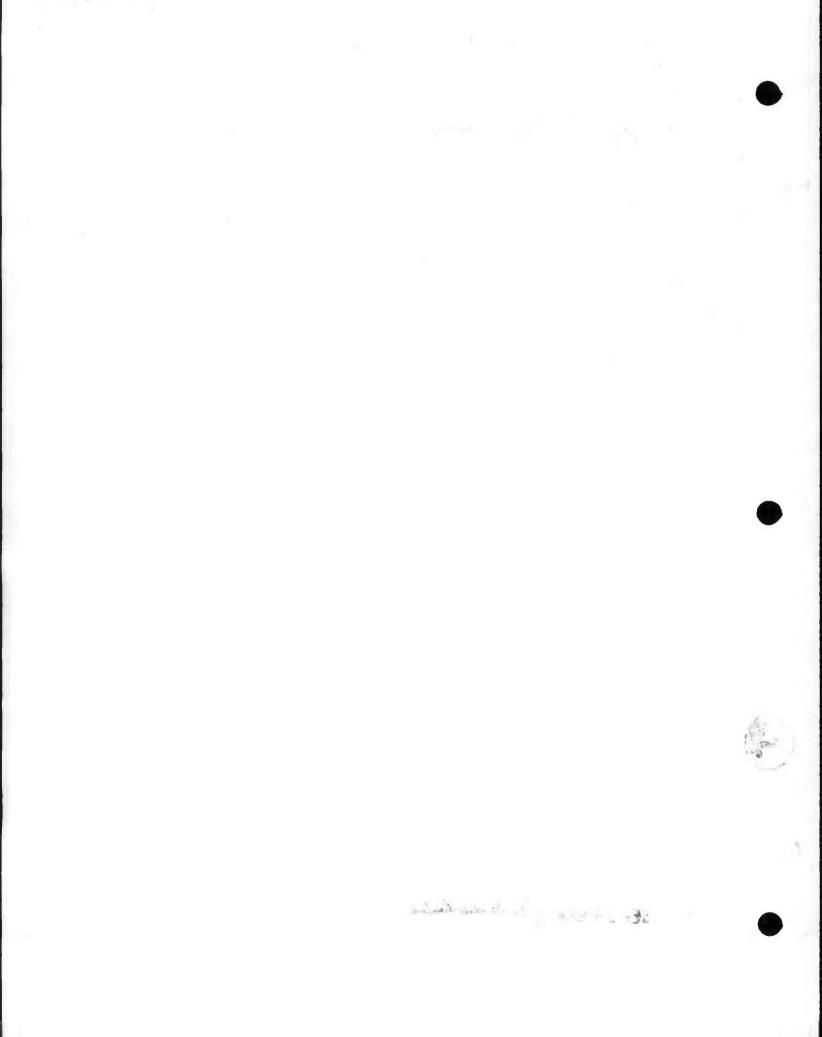
| FOR 1 - STATE REGISTRAR | ITEMS: | 23 PART I, 27 PER MEO G-715 9/28/94 reb STATE OF MARYLAND / DEPARTMENT OF HEALTH AND N CERTIFICATE OF DEATH | MENTAL HYGIENE REG. NO. |
|------------------------------------|--------------------------|---|----------------------------|
| 1. DECEDENT'S NAME (Firs MIRIAN | t, Middle, Last) JETT | | 2. DATE OF DEATH DAY AUG |

| | 1. DECEDENT'S NAME (First, Middle, Last) MIRIAN JETT | | | | | 2. DATE OF DEATH MONTH AUG | DAY YI | 3. TIME OF DEATH |
|---------------|---|--|-------------------------------------|---------------------|---|--|------------------|---|
| | | | | | - | 2 | 1 9 | |
| | 4. SOCIAL SECURITY NUMBER | 5, SEX 8. | AGE (In yrs. lest birthday) YRS. | MONTHS DAYS | | 7. DATE OF BIRTH (Month, Day Year) | 8. | BIRTHPLACE (State or Foreign Country) |
| | 9a. FACILITY NAME (If not institution, give s | | THS. | AL 01711 | | 1-19-19 | 190 11 | PArylano |
| ۳ | JOHNS HOPKIN | | | | N OR LOCATION OF D LTIMORE | | 9c. COUNTY | OF DEATH |
| 5 | RESIDENCE OF DECEDENT | | | | | | | |
| DIRECTOR | 106. COUNTY | 1 | 10c. C1 | Y, TOWN OR LO | CATION | | | 10d. INSIDE CITY LIMITS? |
| | 10e. STREET AND NUMBER | | 12 | 11/11/ | nove | | | 1 PYES 2 NO |
| FUNERAL | 1815 N. Cho. | dor < | Troot | - | 10f. ZIP CODE | ó | 10g. CITIZEN | OF WHAT COUNTRY? |
| ٣ I | 11. MARITAL STATUS | 12. WAS DECEDENT E | VER IN U.S. ARMED | 13 WAS D | ECENDENT OF HISPE | NIC ORIGIN? (Specify Ye | 14 | RACE — American Indian, |
| | 1 Never Married 2 Married | FORCES? 1 [| YES 2 NO | If yes, | specify Cuber, Mexic ES 2 2 NO Speci | an, Puarto Rican, atc.) | 14. | Black, White, atc. |
| BÁ | 3 Widowed 4 Divorced | | | 1 | | | | BIACK |
| ETED | 15. DECEDENT'S EDUI (Specify only highest grade | CATION completed) | 16e. DECEDENT'S (Give kind of | work done during | TION most of working | 16b. KIND OF BU | ISINESS/INDUST | TRY |
| 밁 | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT u | So round.) | | | | 140 |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | 1' | | 709 | 18 MOTHER'S N | AME (F)rst, Middle, Maider | -Cumama) | |
| | mariaN. | Sell | | | Sen | ta C | PAIS | 9 |
| TO BE | 19 INFORMANT'S NAME (Type/Print) | 7 4 4 4 | 19b. MAILING | ADDRESS (Street | and Number or Rural | Floute Number, City or To- | vn Stete, Zip | fus C |
| F | MS Denla C | RAIG | 1815 | N. | herte | 15t. 6 | Alto | nove M/2/2/3 |
| | 20g. METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Remo | oval from Stata | 20b. PLACE AND DATE | OF DISPOSITION | Numeroy L | 20c. LC | OCATION - City | or Togen, State |
| | 4 Donation 5 Other (Specify) | ENSEE 1 | HEDUIL | 22 MAME | AND ADDRESS OF | 100 | 14/01 | W. 7/W |
| | War ale | 10. | 4 - | 103 | PhLik | iss Fun | CIM | nome |
| _ | resign | t. Lu | 22 | 222 | 2/W. NO | Th HUC, E | Alby | md21216 |
| | 23 PART i. Enter the diseases, or c shock, or heart fellurs. | complications that course List only ona cause | on sach iins. | not antar ths r | noda of dying, suc | ch as cardiac or resp | iratory arrest | , Approximsta interval Batween |
| | iMMEDIATE CAUSE (Final disease or condition | CONGENT | AL CORONARY A | ARTERY AN | OMALY | | | Onset and Death |
| 1 | resulting in death) | l | AS A CONSEDUENCE O | | OT 17 L | | | |
| z | | | | | | | | |
| | Sequantially list conditions, if any, isading to immediata | DUE TO (OF | AS A CONSEQUENCE D | F): | | | | |
| 2 | CAUSE (Disease or Injury | DUE TO (OF | AS A CONSEQUENCE O | | | | | |
| CERTIFICATION | that initiated events resulting in death) LAST | DOE 10 (OF | AS A CONSEQUENCE O | r): | | | | |
| 8 | | 1, | | | | | | |
| ¥ | PART ii. Other significant condition | s contributing to da | sth but not reaulting | in the undarly | ing causa givan in | Part I, 24a. WAS AN | | 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO |
| EDICAL | | | | | | 1 YES | 2 🗌 NO | COMPLETION OF CAUSE OF DEATH? |
| Σ | DID TOPACCO LIST CONT | IDLITE TO CALL | E OF BEATH | | | \ | | 1 _ YES 2 _ NO |
| AN | DID TOBACCO USE CONTE | CIBUIE TO CAUS | 28. PLACE OF DEA | | | иПП | | |
| 2 | EXAMINER? 1 7 YES 2 NO | HOSPITAL: | NOutpetient 3 DOA | OTHER: | ome 5 🗆 Residence | a C Other (D) | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 28s. DATE OF INJ | URY 28b. TIM | IE OF 28c. I | NJURY AT | 8 U Other (Specify) 28d. DESCRIBE HOW | INJURY OCCUR | ED |
| 87 P | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, 1 | rear) IN. | | VORK? YES 2 NO | | | |
| | 3 Suicide 6 Could not be | 28e. PLACE OF IN | IJURY — At home, farm, (Specify) | street, fectory, of | fice | 28f. LOCATION (Street City or Town, State | and Number or F | Rural Route Number, |
| COMPLEIED | 4 Homicide detarmined | | | | | Only or rown, state | | |
| Į | one | | knowledge, death occurr | | | | | |
| 5 | | R: On the basis of axam | ination and/or investigation | on, in my opinion | , death occured at the | time, data and piece, e | nd due to the ca | suse(s) and manner as stated. |
| H H | 296. SIGNATURE AND TITLE OF CERTIFIER | . 11 | | | 29c. LICENSE NU | | 29d. DATE SI | GNED (Month, Day, Year) |
| | Medou 1 | 1. This | (mm.) | | 0.C. | ч.с. | AU | G 22/94 |
| | 30. NAME AND ADDRESS OF PERSON WHO | 10 | OF DEATH (ITEM 27) (Type | | | | | |
| | 31. DATE FILED (Month, Day, Year) | | 111 Penn | Stree | t, Balt | imore, Ma | rylan | d 21201 |
| | SEP 0 8 1994 | 11. 14 | or hardall | | | | | |



Item#1,6 Per F.H. Film# G-715 09/08/94 R.M.
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | _ | REGISTRAR | | CERTIF | ICATE OF | DEATH | REG. NO |) <u>,</u> | |
|--|-------------|--|--|--|--|-----------------------------|---|-------------------|---|
| | | 1. DECEDENT'S NAME (First, Middle, Last) CALVIN | 101 | IEC | 10 | | 2. DATE OF DEATH MONTH D | AY YE. | 3. TIME OF DEATH |
| | | CALVIN | JON | E (In yrs. last birthday) | JR # UNDER 1 YEAR | E 1800 TO 01 1800 | SEPTEMBER | | |
| | | 4. SOCIAL SEC 218-07-465 | 1 | 2 80 YRS. | MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | NRTHPLACE (State or Foreign country) |
| should | | 9a. FACILITY NAME (If not institution, give a | treet and number) | | 9b. CITY, TOWN (| OR LOCATION OF DE | | 9c. COUNTY | OF DEATH |
| 2,3 | СТОВ | THE JOHNS HO | PKINS HOSPI | TAL | BALT | IMORE CI | TY | | |
| Jes 1, | REC | 10a. STATE 10b. COUNTY | , | 10c. CIT | Y, TOWN OR LOCAT | TION | | | 10d. INSIDE CITY |
| it. Pages | 띰 | md. | | | BAITO | , | | | LIMITS? |
| permit | 3AL | 10e. STREET AND NUMBER | , , , , | 1 | 101 | ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? |
| 020 physician. burial-transit | FUNER | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | | 10 990 050 | 212/2 | 3 | 4 | 15. |
| | | 1 Never Married 2 Married | FORCES? 1 YES | 2 X NO | If yes, sp | | iiC ORIGIN? (Specify Ye n, Puerto Rican, etc.) | a or No 14. | RACE — American Indian, Black, White, etc. |
| 215-0 attending se as the | D BY | Widowed 4 Divorced | | 7 | | | | | Black |
| | TED | 15. DECEDENT'S EDU- (Specify only highest grade | completed) | 16a. DECEDENT'S (Give kind of life, Do NOT u | WORL OCCUPATION Work done during moise retired.) | ON ast of working | 16b. KIND OF BU | SINESS/INDUST | я́У |
| | COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | ROTING | | | BOT | 4-57 | terl |
| S de la | SON | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Maiden | | |
| क दिन् | BE (| | es Se. | | | NANC | DA | Vi5 | |
| MA retain 5 shor | 0 | 19a. INFORMANT'S NAME (Type/Print) SARAh Buck | | 19b. MAILING | AODRESS (Street a | | Ploute Number, City or Tow | n, Stete, Zip Cod | 112/5 |
| | | 20a. METHOD OF DISPOSITION | 20 | b. PLACE AND DATE | OF DISPOSITION (No | Jood 4 | OATE 20c. LO | CATION — City | or Town, Slate |
| Tection E | | 1 X Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | | HABUT | other place) Mes | x.19/ | 7/9/9 A | VonThe | mel. |
| ALTIM death. Page funeral dire cxaminer n | | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | 22. NAME AF | ID AOORESS OF FA | CILITY | 21510 | 5+ |
| BALT er death. the funera val. | | Talmen | Bill | | BeTI | ts Fun | chal HA | mu 112 | 3N Sandyan |
| hours after bours after of removal medical | | 23. PART I. Enter the diseases, or c shock, or heart fellure. | complications that cause List only one cause on | ed the deeth. Do eech line, | not enter the mo | de of dying, auci | h as cerdiec or reap | iretory erreat, | Approximata Interval Between |
| 24 hor filled tion, or the m | | IMMEDIATE CAUSE (Final disease or condition | 1/1100 | ension | | | | | Onset and Death |
| d within ompletely i, crema | | resulting in death), | | A CONSEQUENCE O | DF): | | | | 12 hour |
| 9 2 6 | Z | Sequentially list conditions, | Massive | Item | prrhage | 0 | | | Vo hours |
| OX 68 s be execut sician and c nor to bun traumatic | RTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS | A CONSEQUENCE O | F): / | | | | |
| physicate property per the per the property per the property per the property per the property per the property per the property per the property per the property per the property per the property per the property per the per the per the property per the per t | FIC | CAUSE (Disease or Injury thet initialed events | DUE TO (OR AS | A CONSEQUENCE O | IF): | | | | |
| ending | E | resulting in death) LAST | d | | | | | | |
| the death the atte d Mental injury. | L CEI | PART II. Other significent condition | s contributing to death | but not resulting | In the underlying | ceuse given in | Part I. 24e. WAS AN | AUTOPSV | 24b. WERE AUTOPSY FINDINGS |
| 2 20 2 | ICAL | | | | the anderlying | g coude given in | PERFOR | RMED? | AWAILABLE PRIOR TO COMPLETION OF CAUSE |
| | MEDI | | | | | | YES 2 | ON | OF DEATH? |
| | ä | DID TOBACCO USE | CONTRIBUTE TO | CAUSE O | F DEATH | YES NO | | | |
| ate D | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 28. PL | ACE OF DEATH (Ch | eck only one) | | |
| the Si | HYS | 1 VES 2 NO | 28e. DATE OF INJURY | | | e 5 Residence | 8 Other (Specify) 28d. DESCRIBE HOW I | WILLBA OCCUBE | 0 |
| marked | BY PI | 1 Natural 5 Pending | (Month, Day, Year) | | JURY WO | RK? | LOC. DESCRIBE NOW | NOON OCCORE | |
| 2 2 10 | | 3 Suicide 8 Could not be | 28e. PLACE OF INJUR building, etc. (Spi | IY — At home, farm, | atreet, factory, offic | | 281. LOCATION (Street City or Town, State) | and Number or Ri | ural Route Number, |
| OR ATTER DIRECTOR hours after Item 28 | COMPLETED | 4 Homicide determined | | | | | Only of Towns, State) | | |
| AL OR A AL DIREC 72 hours | AP. | | CIAN: To the beat of my kno | | | | | | |
| IOSPITUNER VITHIN | 00 | 2 MEDICAL EXAMINE | | on and/or Investigation | on, in my opinion, d | eath occured at the | time, date and place, an | nd due to the car | use(a) and manner as stated. |
| TO THE HOSPITAL OF TO THE FUNERAL D TO THE FUNERAL D TO FIED WITHIN 72 ho IMPORTANT: If IN | BE | 29b. SIGNATURE AND TITLE OF CERTIFIES | .000 | | | 29c. LICENSE NUN | | 29d. DATE SIG | NED (Month, Day, Year) |
| 223 | 2 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETEO CAUSE OF O | EATH (ITEM 27) (Type |), Print) | m163 | 1 | 11/ | 3174 |
| | | | 10 TOWER | | | okinis | HOSPITAL | -, Br | LTIMORE |
| | | 31. DATE FILED (Month, Day, Year) | 22, REGISTRAR'S SIG | TURE | | | | | |
| | | SEP 0.8 1994 | 1 | | | | | | II George |



7:05a B. BIRTHPLACE (Stote or Foreign)C

Approximete interval Between Onset and Death 10 days

6 years

#1443

. Fisher, M.D., 5530 Wisconsin Ave, Chevy Chase, MD

20815

REG. NO.

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| DIVISION OF VITAL RECORDS, | 3 |
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2

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

| | | 1. DECEDENT'S NAME (First, Middle, Lest) David H. | | Kus | hner | | | | - 1 | | DAY | YEAR | 3. TIME OF DEATH | |
|--|---------------|---|--|---------------------|--------------------|--------------|-----------------|-------------------------------|---------------|--|---------------|-------------------------------|--|--|
| | | 4. SOCIAL SECURITY NUMBER | 5. SEX | | rs. last birthday) | IF UNDER | 1 VEAR | IF UNDER 2 | \rightarrow | August | 31,19 | | 7:05a PLACE (State or Foreign) | |
| 모 | | 579 60 0821 1X M 2 G F 89 YRS. MONTHS DAYS HOURS MIN. Sept. 2 | | | | | | | | Sept. 29 | ,1904 | Country | shington | |
| 3 should | В | 99. FACILITY NAME (If not institution, give street end number) 8100 Connecticut Avenue, #904, Chevy Chase 90. COUNTY OF I | | | | | | | | | | | | |
| 1, 2, | 5 | RESIDENCE OF DECEDENT | | | | | | | | | | | | |
| permit. Pages 1, 2, | DIRECTOR | Maryland Mont | gomery | | 10c. CIT | che | | ion Chas | е | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| tis i | FUNERAL | 100. STREET AND NUMBER 8100 Connectic | ut Aven | ue, | #904 | | | ZIP CODE 0815 | | | USA | 10g. CITIZEN OF WHAT COUNTRY? | | |
| -AND 21215-0020 the hospital or attending physician. detached for use as the burial-transit once. | BY FUN | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE W | YES : | 2 MO | | If yes, spe | ENDENT OF scify Cuben, 2 M NO | Mexican, | C ORIGIN? (Specify Your Puerto Ricen, etc.) | ee or No- | 14. RACE Black Specif | - American Indien, White, etc. | |
| 15- tendir | ED | 15. DECEDENT'S EDU | CATION | 16 | ie. DECEDENT'S | USUAL O | CCUPATIO | NA | | 16b. KIND OF B | 1 | ATON | WIIICE | |
| or at | | (Specify only highest grade Elementary/Secondary (0-12) | | | (Give kind of a | work done | during mos | st of working | | 100. KIND OF BI | USINESS/INDL | STHY | | |
| YLAND 2- by the hospital of the detached for at once. | COMPLET | 201101101111111111111111111111111111111 | 5+ | | hysic | ian | | | | Medica | al | | | |
| MARYLAND retained by the hospit 5 should be detached notified at once. | Ö | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTHE | R'S NAM | E (First, Middle, Maide | n Sumame) | | | |
| ₹ ₹ ₹ | BE | Isaac J. Kushn | er | | | | | | | Pack | | | | |
| MARYI retained by 5 should be notified at | 6 | 19e. INFORMANT'S NAME (Type/Print) | | | | | | | | ute Number, City or To | | | 00075 | |
| | | Jane Papish 200. METHOD OF DISPOSITION | | | | _ | | _ | ad, | Chevy Cl | | | | |
| ORE e 6 may rector, pa | | 1 X Burlel 2 Cremetion 3 Reme 4 Donation 5 Other (Specify) | oval from State | 20b. PL | ACE AND DATE | ther place) | Com | me of | · · · 0 | 2/94 Was | ocation — c | ity or To | vn, State | |
| ALTIMOR Jeath. Page 6 m funeral director. | | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | Hua | 2 1210 | 22. | NAME AN | D ADDRESS | OF FACI | LITY | | | , DC | |
| 0 = 0 | | 1/ Aunella | reku | m | | Fa | lls | Chu | rch | | 2046 | | | |
| in by reme | | 23. PART i. Enter the diseases, Dr o shock, Dr heart feliure. | complications the | t ceused th | ne deeth. Do r | not enter | the mod | de of dyln | g, such | ss cerdiec or ree | piratory srre | st, | Approximete interval Between | |
| | | IMMEDIATE CAUSE (Finel | | | | | | | | | | | Onset and Dea | |
| 760, ad within ompletely fill. 1, cremation, event, the | | reaulting in death) | | moni | | | | | | | | | LO days | |
| P 0 0 7 6 | _ | | | | e Heal | | a i 1 : | 1120 | | | | | 6 year | |
| 5 ° 0 E | CERTIFICATION | Sequentially liet conditions, if any, leading to immediate | | | NSEQUENCE OF | | атт | ure | | | | | o year | |
| BOX | CAT | cause. Enter UNDERLYING CAUSE (Disease or injury | C. | | | | | | | | | | | |
| O. B ertificat ing phy open p | E | that initieted events | DUE TO | (OR AS A CO | INSEQUENCE OF | F): | | | | | - | | | |
| e H | H | resulting in death) LAST | d | | | | | | | | | | | |
| S 5 9 5 | | PART ii. Other aignificant condition | a contributing to | deeth but | not resulting | In the ur | derlying | ceuse gir | ven in P | art i. 24a. WAS A | | 24b. | WERE AUTOPSY FINDING | |
| ECORD quires that the n signed by th f Health and M ows any inj | MEDICAL | Ascites of un | known e | etiol | ogy | | | | | 1 _ YES | RMED? | | AMAILABLE PRIOR TO COMPLETION OF CAUSE | |
| RECOl | ij. | | | | | | | | | | - 63 110 | 1 | OF DEATH? 1 YES 2 NO | |
| AL RE law requass been Dept. of 23 sho | | | | | | | | | | _ | | | | |
| F VITAL F SICIAN: The law r certificate has be the State Dept. d, or item 23 s | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | | | ACE OF DEA | ATH (Checi | k only one) | | | | |
| VI. | 1S/ | 1 TES 2X NO | 1 Inpatient 2 | ER/Outpatie | nt 3 🗆 DOA | OTHER | t: eing Home | e X∷ Resi | denca 6 | ☐ Other (Specify) | | | | |
| NG PHYSICI ther this cert eath with th marked, o | PHY | 27. MANNER OF DEATH 1 Netural 5 Pending | 28a. DATE OF (Month, De | INJURY ay, Year) | 28b. TIM INJ | URY | 28c. INJU | RK? | | 28d. DESCRIBE HOW | INJURY OCC | JRED | | |
| ONG POING PAter death | B | 2 Accident Investigation | 29 DI ACE O | E IN HIPV | At home, ferm, s | М | | ES 2 | - | | | | | |
| DIVISION OF VITOR OR ATTENDING PHYSICIAN: OR ATTENDING PHYSICIAN: DIRECTOR: After this certifica hours after death with the St. Item 28 is marked, or it | | 3 Suicide 6 Could not be determined | building, | etc. (Specify) | At nome, rerm, i | street, ract | ory, office | • | ' | 28f. LOCATION (Street City or Town, State | end Number o | r Rural Ri | oute Number, | |
| DIVISION OF ATTENCE OF ATTENCE OF ATTENCE OF THE AT | Ē | 290. CERTIFIER | CIAN. To the house of | | | | | | | | | | | |
| ¥ 4 5 = | COMPL | (Check only one) | | | | | | | | | | | and manner as stated. | |
| HOSPITAL FUNERAL WITHIN 72 STANT: If | 111 | 296. SIGNAPORE AND TITLE OF CERTIFIER | | 1. | | | | 29c. LICEN | | | | | (Month, Day, Year) | |
| TO THE HOSP! TO THE FUNER be filed within IMPORTANT: | O BE | Mary 7 | radi | 14 | ND | | | D138 | | | ▶ 8/ | 31/ | 94 | |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

DHMH-16 Rev 1/89

| BALTIMORE, MARYLAND 21215-0020 | ath. Page 6 may be retained by the hospital or attending physici | ineral director, page 5 should be detached for use as the burial-t |
|--|--|---|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | . OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within clours after death. Page 6 may be retained by the hospital or attending physici | DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-t |
| DIVIS | OR ATTEN | DIRECTOR |

rial-transit permit. Pages 1, 2, 3 should ysician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | | ERTIFIC | CALE | OF DEA | EH | | REG. NO. | | | |
|---------------|---|-------------------------|------------------|--|----------------|-----------------------------|----------------|------------------|----------------|------------|-------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE O | OF DEATH DA | v | YEAR | 3. TIME OF DEATH |
| | HELEN SKAGGS KA | HN Helen | Kahn | | | | | 09 | 0 | | 94 | LOSOA M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 8. | AGE (In yrs. la: | - | IF UNDER 1 YE | | R 24 HRS. | 7. DATE C | F BIRTH | | 8. BIRTH | PLACE (State or Foreign |
| | 212-12-7105 | | 80as. | PAS. MONTHS DAYS HOURS MIN. (Morth, Dey, Year) 1913 WE | | | | | WES | T VIRGINIA | | |
| | Se. FACILITY NAME (If not institution, give st | reet end number) | | | 96. CITY, TO | WN OR LOCAT | ION OF DE | EATH | | 9c. COU | NTY OF D | EATH |
| DIRECTOR | STELLA MARIS | HOSPICE | | | | TOWSO | N | | | BALTIMORE | | |
| ַ | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | | | | | | | | | | |
| <u> </u> | MARYLAND | | | | TOWN OR L | | | | | | | 10d. INSIDE CITY LIMITS? |
| | | | | BAI | LTIMO | | | | | | | 1 X YES 2 - NO |
| FUNERAL | 100. STREET AND NUMBER | , | | | | 10f. ZIP COL | | | | | | VHAT COUNTRY? |
| 핃 | 123 W. CONWAY ST | | | | | | 201 | | | | JSA | |
| 5 | 11. MARITAL STATUS 1 Never Merried 2 Merried | 12. WAS DECEDENT ET | VER IN U.S. AF | RMEO NO | 13. WAS | DECENDENT s, specify Çub | OF HISPAN | NC ORIGIN? | (Specify Year | or No- | 14. RACE Black | — American Indien, c, White, etc. |
| B | 3 Widowed 4 Divorced | IF YES, GIVE WAR | | | 1 🗆 | YES 2 XNO | Specify | y: | ,, | | Speci | |
| | 15. DECEDENT'S EDUC | ATION | 140- 04 | CEDENTIO | 1 | | | | | | | WILLE |
| 2 | (Specify only highest grade | completed) | (0 | CEDENT'S U live kind of wo Do NOT use | irk done durir | g most of work | ing | 16b. | KIND OF BUS | INESS/IN | DUSTRY | |
| ٦ ا | Elementary/Secondary (0-12) | College (1-4 or 5+) | | ECRETA | ai ii | | | | HEND1 | ראזכי ז | TD F | ISPENSER |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | <u> </u> | | 71/1 | | | | | | AID L | ISPENSER |
| | | AGGS | | | | 18. MO | | | iddle, Maiden | Surneme) | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | ACCO. | | | | | EMMA | | | | | |
| ဥ | -3-00-3-0-3-0-3-0-3-0-3-0-3-0-3-0-3-0-3 | 7. [] 7. | | | | reet and Number | | | | | | |
| | | AHN | | | | VAY ST | . BAI | | _ | | | |
| | 20a. METHOD OF OISPOSITION 1 Description 2 Cremation 3 Remo | oval from State | | AND DATE OF | | | | OATE | | | City or To | |
| | 4 Donation 5 Other (Specify) | Chinee | BALT. | IMORE | _ | | _ | 9-5-9 | 4 BA | ALTIN | MORE, | MD |
| | 21. SERVICE UP | ENSEE | - | | 22. NAN | L LEVI | INSON | CILITY I & BF | ROS, T | NC. | | |
| | Jack 1 | y der | co | | | | | | | | MORE | , MD 21215 |
| CERTIFICATION | iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR | | QUENCE OF) | | ER | | | | | | Interval Between Onset and Death Mos, |
| 5 | | | | - | | | | | | | | |
| | PART il. Other significant condition | a contributing to de | ath but not | resuiting in | the under | iying ceuse | given in | Part I. | 24a. WAS AN | | 24b. | WERE AUTOPSY FINDINGS |
| EDICAL | | | | | | | | | PERFOR | 1 | | AVAILABLE PRIOR TO COMPLETION DF CAUSE |
| | | | | | | | | _ | | Allo | | DF DEATH? 1 YES 2 NO |
| 5 | DID TOBACCO USE (| CONTRIBUTE | O CAU | SE OF | DEATH | YES [|] NC | X | | | | |
| ¥ | 25. WAS CASE REFERRED TO MEDICAL | | | | | 6. PLACE OF I | DEATH (Ch | eck only one |) | | | |
| S | 1 Tes 2 No | HOSPITAL: | VOutpatient 3 | DOA | OTHER: | Home 5 🗆 R | leeldence | eX Other | (Specific) TT- | | | |
| PHYSICIAN: M | 27. MANNER OF DEATH | 28e. DATE OF INJ | URY | 28b. TIME | OF 280 | INJURY AT | | | RIBE HOW IN | | | |
| | 1 Natural 5 Pending Investigation | (Month, Day, 1 | rear) | INJU | | WORK? | □ NO | | | | | |
| BY | 2 Accident Investigation 3 Suicida 8 Could not be | 28e. PLACE OF IN | JURY — At ho | ome, farm, atr | reet, factory, | office | | 281. LOCA | FION (Street a | nd Number | or Rural R | loute Number, |
| | 4 Homicide determined | building, etc. | (Specify) | | | | | City or | Town, State) | | | |
| COMPLETED | 290. CERTIFIER CERTIFUNG BUYON | NAM: To the heat of my | leased ada a de | | | | 72.55 | | | | | |
| Σ | | CIAN: To the best of my | | | | | | | | | | 5.10.00 |
| 8 | | | 11011011 0110701 | inivestigation, | , in my opine | on, death occu | lined at title | time, date o | nd place, and | due to tr | re ceuse(e |) end menner se stated. |
| BE | 29th SIGNATURE AND TITLE OF CERTIFIER | 59.000 | | | | esc. LIC | ENSE NUN | MBER | | 29d. DAT | E SIGNED | (Month, Day, Year) |
| 0 | 4 Chelles | | rein | | | 77 (| 756 | 43 | | P (2 | 9/1/ | 94 |
| | 30. NAME AND ADDRESS OF PERSON WHO | | | | | | | | | 7 | 1 | |
| | Kendall R. Faulkn | er, MD | 2300 I | Dulane | ey Val | lley R | oad, | Tows | on, Ma | ryla | and | 21204 |
| | 31. STEP IN RIGHT SAL | Of Delight Ra | PRE | | | | | | | | | |
| | 021 00 1001 | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an order of the death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLAND | / DEPAR | RTMENT | OF H | EALTH . | AND I | MENTA | L HYGIEN | E | | |
|------------------|--|---|-----------------------------|-----------------|--------------|--------------------|------------|---------------------|--------------------|-----------------------------------|--------------------|--|
| - 1 | 1. DECEDENT'S NAME (First, Middle, Last) | | | 77 | | Lo ha / t. | - | | OF DEATH | | \- | 3. TIME OF DEATH |
| | LILLIAN KOG | | | | | | | SEP. | r. 2, ^M | 1994 | YEAR | 4:15 AM M |
| | 217-12-9905 | 1 M 2 AF 91 YRS. MONTHS DAYS HOURS MIN. MAY 13, 1903 Country NEW YOR | | | | | | | | PLACE (State or Foreign W YORK | | |
| TOR | 9e. FACILITY NAME (If not institution, give street NORTH OAKS HEALTH C | | | эь. сіту ВАІ | LTIM | R LOCATIO DRE | N OF D | EATH | | | NTY OF DI | |
| DIRECTOR | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN (| OR LOCATI | ION | | | | | 1 | 10d. INSIDE CITY |
| | MARYLAND BALTI 100. STREET AND NUMBER | IMORE | В. | ALTI | MORE | | | | | 40m CITI | TEN OF W | 1 YES 2 NO |
| FUNERAL | 725 MT. WILSON LAN | JF. | | | | 2120 2120 | 8(| | | USA | YEAR OF THE | HAT COUNTRY? |
| N. | 11. MARITAL STATUS 12 | ARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or I | | | | | | | or No— | 14. RACE | — American Indian, | |
| ВУ Р | 1 Never Merried 2 Merried 3 Widowed 4 Divorced | IF VES GIVE WAR OR DATES | | | | | | en, Puerto F ly: | Ricen, atc.) | | Specia | , white, etc. |
| | 15. DECEDENT'S EDUCATI | 10N 180 I | DECEDENT'S | LIGHAL O | CCLIDATIO | A1 | | 1.00 | | | | WIIII |
| ETE | (Specify only highest grade con | mpleted) | (Give kind of the Do NOT us | work done | during mos | N it of working | 7 | | KIND OF BUS | | | |
| IPL | Elementery/secondary (0-12) | 2 P: | ROPRI | ETOR | | | | | KOGAN | REAL | JTY | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) SIMON HELPRIN | N | | | | 18. МОТЫ | FINN | ME (First, A | Middle, Maiden | Surname) | | |
|) BE | 19a. INFORMANT'S NAME (Type/Print) | 1 | 19b. MAILING | ADDRESS | S (Street er | nd Number o | or Rural i | Route Numb | per, City or Town | , State, Zip | Code) | |
| 5 | DR. STANLEY KOGAN | | 3515 | | | | | | O., MD | | 208 | |
| | 39s. METHOD OF DISPOSITION ↑ Burial 2 Gremation 3 ☐ Remove | trom State | E AND DATE | OF DISPOS | ITION (Nar | ne of | | DATI | | CATION — | | |
| | BALTIMORE HEBREW 9-4-94 BALTIMORE, PID | | | | | | | | | | | |
| | 21. SIGNATURE OF TUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. | | | | | | | | | | | |
| _ | 6010 REISTERTOWN RD. BALTO., MD 21215 | | | | | | | | | | | |
| | 23 ART i. Enter the diseases, or comehock, or heert fallure. Lie | npiloations that caused the c | death. Do r | not enter | the mod | de of dyin | ng, suc | h ae cerd | lac or reepi | ratory err | eet, | Approximate Intervel Between |
| | IMMEDIATE CAUSE (Finel disease or condition | C 1 | | | | | | | | | | Onset and Death |
| | resulting in deeth) | Dip hoen | | | | | | | | | | DAYS |
| - | | DUE TO (OR AS A CONS | EOUENCE O | F): | | | | | | | | |
| ē | Sequentially list conditione, if any, leading to immediate | DUE TO (OR AS A CONS | EOUENCE O | F): | | | | | | | | |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | | | | |
| E | that initieted events resulting in deeth) LAST | DUE TO (OR AS A CONS | EOUENCE O | F): | | | | | | | | |
| GER | d,_ | | | | | | | | | | | |
| A. | PART II. Other eignificent conditione c | ontributing to deeth but not | resulting | in the un | derlying | ceuse gl | ven in | Part i. | 24a. WAS AN | | 24b. | WERE AUTOPSY FINDINGS |
| DIC. | - Hypokusion | | 1 . | | | | | _ | 1 YES 2 | | | AVAILABLE PRIDR TO COMPLETION DF CAUSE DF DEATH? |
| ME | | | 1/20 | lary | Dis | ene | | | | | | 1 NO YES 2 NO |
| ä | DID TOBACCO USE CONTRIB | | | SDI | | UNCE | RTAIN | N 🗆 | | | | |
| PHYSICIAN: MEDIC | | OSPITAL: | ACE OF DEAT | OTHE | r): | | | | | | | |
| HYS | 1 VES 2 NO 1 | □ Inpetient 2 □ ER/Outpetient 28s. DATE OF INJURY | 3 DOA | 4 S Nun | 28c, INJU | | Idence | 8 Other | | LUIMI AAA | | |
| | 1 Natural 5 Pending | (Month, Day, Year) | | URY M | WOF | | NO | 280. DEŞ | CRIBE HOW IN | NUMA OCC | URED | |
| BY | 2 Accident Investigation 3 Suicide 8 Could not be | 28e. PLACE OF INJURY — At h | nome, ferm, o | street, fect | | | | | ATION (Street a | nd Number | or Rural R | oute Number, |
| ETED. | 4 Homicide determined | building, etc. (Specify) | | | | | | City o | or Town, State) | | | |
| PE | 29e. CERTIFIER Check only | N: To the best of my knowledge, d | leath occum | ed at the ti | me, date o | and place, o | end due | to the ceu | se(e) end man | ner ee state | ed, | |
| COMPL | | On the beele of exemination end/or | | | | | | | | | | end manner ee stated. |
| BE C | 995. SIGNATURE AND TITLE OF CENTIFIER | | | | | 29c. LICEN | ISE NUN | MBER | | 29d. DATE | SIGNED | (Month, Day, Year) |
| 10 | There | | | | | D | 38 (| 675 | | > C | 1/2/ | 194 |
| | JOEL MESHU | OMPLETED CAUSE OF DEATH (IT | EM 27) (Type. | Print) | 5R 5 | | | | MO | 21 | 23 | O |
| | 31. DESTRUCTION TO DA Sale | DE MERCHANIST CHESTANTE | , , | - 500 | | | / | - | | | | |
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| RECORDS, P.O. BOX 68760. | |
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Pages permit. burial-transit hospital or attending physician. page 5 should be detached for use as the the notified at å must director, examiner funeral the medical filled in by 0 and completely fille o burial, cremation, the event. prior to the attending physician Mental Hygiene prior to other 6 any injury, has been signe bept, of Health T 23 shows a HOSPITAL OR ATTENDING PHYSICIAN: The After this certificate I death with the State 0 marked, 60 DIRECTOR: / item 28 FUNERAL within 72 h IMPORTANT: If THE THE

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94 26348 FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DEWEY JOHN KINSEY inses 2.630 M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreig 1 XM 2 | F 301244206 62 YRS. 04-28-132 OHIO 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH WASHINGTON ADVENTIST TAKOMA PARK MONTGOMERY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND PRINCE GEORGE 1 YES 2 NO LAUREI 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8403 SPRUCE HILL DRIVE 20707 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Merried
3 Widowed 4 Divorced If yes, specify Cuben, Mexican, Puerto Rican, atc.) 1 TES 2 NO Specify: Specify: WHITE 16a. DECEDENT'S USUAL OCCUPATION
(Olive kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 OGECSTICS SPECIALIST FEDERAL GOVERNMENT 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) WAYDE KINSEY ELSIE RHUDE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSE M. KINSEY 8403 SPRUCE HILL DRIVE LAUREL MD 20707 20a. METHOD OF DISPOSITION 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20s. METHOD OF DISPOSITION

1 Burlal 2 CyCremation 3 Removal from State
4 Donation 5 Other (Specify) BALTIMORE WASHINGTON CREM. 8/30 LAUREL. MARYLAND 22. NAME AND ADDRESS OF FACILITY FLECK FUNERAL HOME, INC. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 7601 SANDY SPRING ROAD, LAUREL, MD 20707 23. PART I. Enter the diseases, or come of the de Do not enter the mode of dying, auch as cardiac or respiratory arrest, shock, or heart failure. List Interval Between Onset and Death IMMEDIATE CAUSE (Finei disease or condition HEART FAILURE TE resulting in death) DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, laading to immediata cause. Enter UNDERLYING ORONARY HEART DISEASE CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? 1 TES 2 XNO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | White the partial of t OTHER:
4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 YES 2 NO 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending Investigation 1 YES 2 NO 2 Accident

28s. PLACE OF INJURY — At home, ferm, street, factory, offica building, ate. (Spacify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town State) 8 Could not be 4 Homicide determined 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the beels

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and/or investigation, in my opinion, death occured at the time, date end place, and due to the ceuse(s) and manner as stated. 29¢ LICENSE NUMBER

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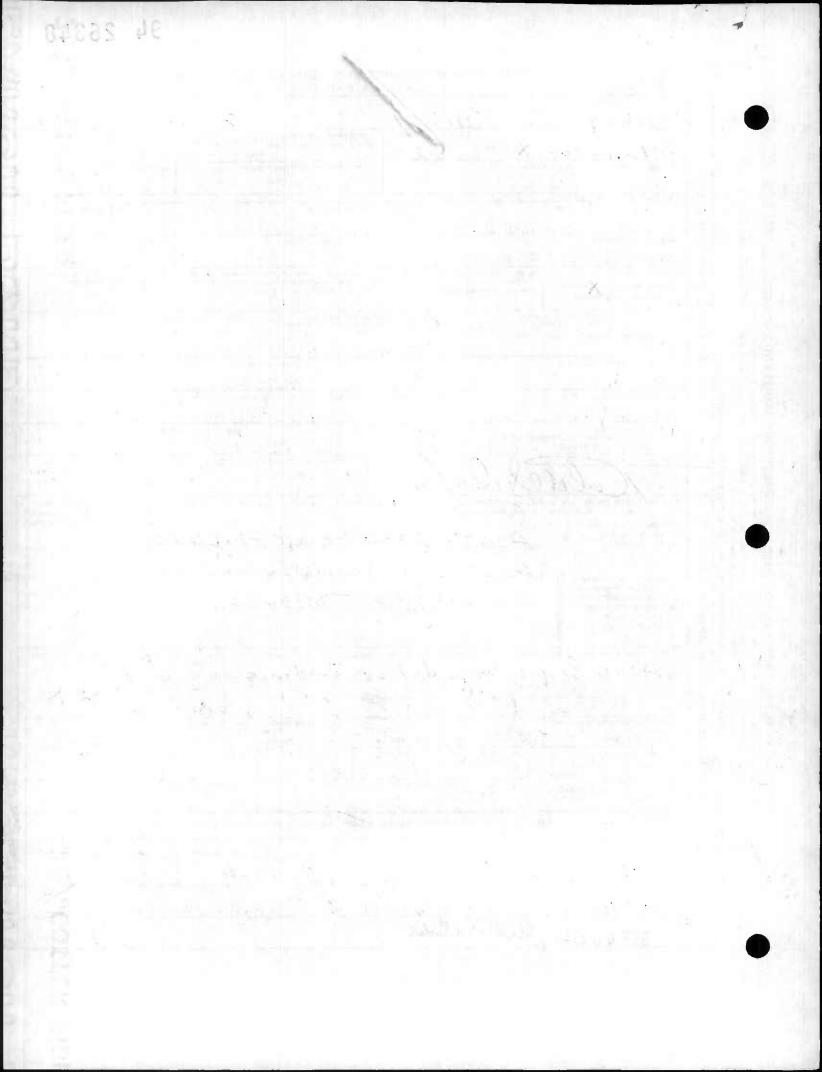
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PLETED CAMEDOF DEATH (ITEM 27) (Type, Print)

M. H CHAUD HRymo. 7610 Curroll And 31. DATE FILED (Month, Day, Year)

12. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - FOR STATE REGISTRAR | | PARTMENT OF HEALTH AND | MENTAL HYGIENE REG. NO. | 74 20045 |
|------------------|---|--|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | so Leak | J. | 2. DATE OF DEATH DAY | YEAR 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 213-36-4311 | 5. SEX 6. AGE (In vis. lest birtho | MONTHS DAVE MOURE MIN | | BIRTHPLACE (State or Foreign Country) |
| TOR | PRESIDENCE OF DECEDENT | Haspital Center | 9b. CITY, TOWN OR LOCATION OF D | | y OF DEATH Balto |
| DIRECTOR | 10a, STATE 10b. COUNTY | 10c. | CITY, POWN OR LOCATION | | 10d. INSIDE CITY LIMITS? 1 V YES 2 NO |
| FUNERAL | 4002 Bedf | ind Rd | 101. ZIP CODE 2 20 | 7 10g. CITIZE | N OF WHAT COUNTRY? |
| ВУ | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES | 13. WAS DECENOENT OF HISPA If yes, specify Cuben, Mexic 1 YES 2 NO Spec | an, Puerto Rican, etc.) | 4. RACE — American Indian, Black, White, etc. Specify: Black |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | Completed) (Give kind life. Do NC | NT'S USUAL OCCUPATION d of work done during most of working OT use retired.) | 166. KIND OF BUSINESS/INDUS | STRY |
| | 17 FATHER'S NAME (First, Middle, Last) | 1 5 | | AME (First, Middle, Melden Surname) | |
| TO BE | ea. INFORMANT'S NAME (Type/Print) | | LING ADDRESS (Street and Number or Rural | Route Mymber City or Toyer, State, Zip 9 | v. md 21207 |
| | 20e,METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remo | oval from State | ATE OF DISPOSITION (Name of | PATE 200. LOCATION - CH | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | March F. | H- West bash Ave | (1,1,1,1,0,0) |
| | 23. PART . Enter the diseases, or c shock, or haert failure. | complications that ceused the deeth. I | | | it, Approximate interval Between |
| | iMMEDIATE CAUSE (Finel disease or condition resulting in death) | DUE TO (OR AS A CONSEQUENCE | | | Onset and Death |
| TION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A CONSEQUENCE | CE OF): | | |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated eventa resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE | EE OF): | | |
| AL | PART II. Other significant condition | s contributing to deeth but not resulting | ing in the underlying causa givan in | Part I. 24s. WAS AN AUTOPSY PERFORMED? | 24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| PHYSICIAN: MEDIC | Hypertens | 9 | V TO | 1 YES 2 NO | OF DEATH? |
| IAN | 25. WAS CASE REFERRED TO MEDICAL | | 28. PLACE OF DEATH (C | heck only one) | |
| SIC | EXAMINER? | HOSPITAL: 1 Unpatient 2 ER/Outpatient 3 DO | OTHER: | | |
| PH | 27. MANNER OF DEATH 1 Natural 5 Pending | 28e. DATE OF INJURY (Month, Day, Year) 28b. | TIME OF 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCU | RED |
| В | 2 Accident Investigation | 28e. PLACE OF INJURY — At home, fer | M 1 YES 2 NO | 28f. LOCATION (Street and Number of | Durat Garage Museum |
| TEO | 4 Homicide 8 Could not be determined | building, atc. (Specify) | THE STREET, INCOME, OTHER | City or Town, State) | Rural Houte Number, |
| COMPLETED | | Ctan: To the best of my knowledge, death oc- | | | |
| BE | 29b. SIGNATUBE AND TITLE OF CERTIFIER | ett M. Brew | Lee M D 3 (| MBER 29d, DATE S | SIGNED (Month, Pay, Year) |
| 5 | 2 1201 W. | COMPLETED CAUSE OF DEATH (ITEM 27) | Type, Print) RMD. NO | tungstit | OSD (venter |
| | 31 SEP 0 8 1994 July | A Strategion of Strategion | 13(/- | V \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | |

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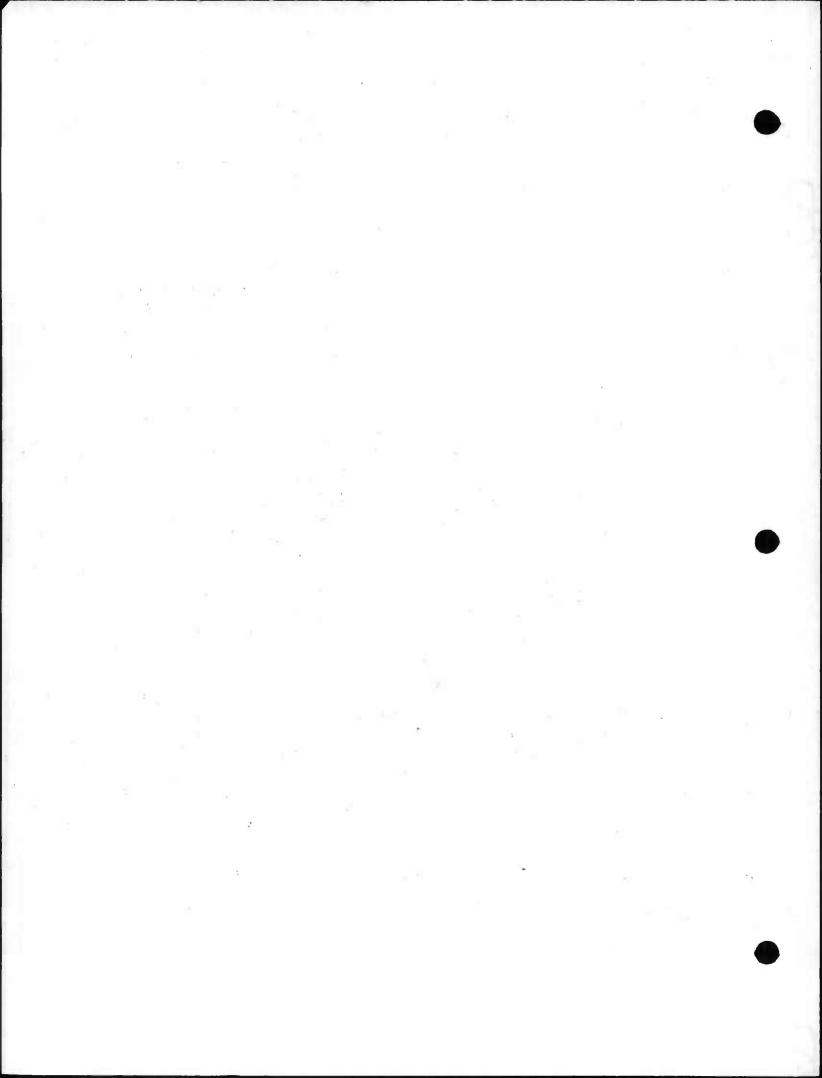
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR Elliot 1:30A Liebow Sept.4. 1994 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. ?, DATE OF BIRTH (Month, Day, Ybar) 8. BIRTHPLACE (State or Foreign 578-20-3741 ty XM 2 □ F 69 Jan.4,1925 Washington, DO 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Holy Cross Hospital Silver Spring Montgomery RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Silver Spring 1 X YES 2 | NO FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 109 Bluff Terrace 20902 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puerto Rican, stc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. FORCES? 1 TO YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 XX X Married Specify: BY 3 Widowed 4 Divorced White ED 15. DECEDENT'S EDUCATION 18s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) 5+Anthropologist U.S. Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Boris Liebow BE Bertha Wecksler 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2 109 Bluff Terrace, Silver Spring, Md. 20902 Harriet Liebow METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Burial 2 Cremation 3 Ram Donation 5 Other (Specify) Judean Memorial Gdn.9-8-94 Olney, Md 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Ives-Pearson Funeral Homes Falls Church, Va. 22046 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death Metastatic disease or condition Carcinoma furtalying reauiting in death) DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 PNO OF DEATH? 1 TYES 2 TNO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [] NO [7] PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? HOSFITAL:
1 D Inpetiant 2 D ER/Outpetiant 3 DOA OTHER: 1 TYES 2 TONO 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c, INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending t YES 2 NO ВY 2 Accident 28s. PLACE OF INJURY — At home, farm, atrest, factory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the besis

IMPORTANT: 290 LICENSE NUMBER BE THE Bell muu u. 2 2 3 AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE SEP 0 8 1994



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| | SARAH | | | | | INE | | | | | | 8:00 P |
| | 4. SOCIAL SECURITY NUMBER 220 46 8063 | 5. SEX 6. A | GE (in yrs. last birthday 87 YRS. | MONTHS 1 | DAYS | IF UNDER | MIN. | Juni | F BIRTH | 1907 | Onic | ACE (State or Foreign |
| | Se. FACILITY NAME (If not institution, give | street and number) | | 9b. CITY, | TOWN C | R LOCATIO | ON OF DEAT | | | 9c. COUNT | | |
| 8 | Bedford Court | | | Si | lve | r Sp | oring | 7 | | Monte | | |
| 5 | RESIDENCE OF DECEDENT | | | | | | | | | | | |
| DIRECTOR | 10a. STATE 10b. COU | | | TY, TOWN OF | | | | | | | 16 | d. INSIDE CITY LIMITS? |
| | Maryland M | ontgomery | S | ilve | | | | | | _ | | YES 2 XNO |
| P.A | | | | | 101 | ZIP CODE | | | | | | AT COUNTRY? |
| FUNERAL | 3701 Internat | 12. WAS DECEDENT EVE | | 12 W | MS DEC | | 906 | OBICIA | (Specify Ye | 1 | | American Indian. |
| B | 1 Never Married 2 Married 3 Mildowed 4 Divorced | 3 X Mildowed 4 □ Divorced IF YES, GIVE WAR OR DATES | | | | | | | ican, atc.) | s or no 1 | Specify: | volte, atc. |
| ETED | 15. DECEDENT'S El (Specify only highest gri | | 16a. DECEDENT | S USUAL OC | CUPATIO | N | | 16b. | KIND OF BU | SINESS/INDUS | | cabran |
| | Elementary/Secondary (0-12) | College (1-4 or 5+) | IIIe. Do NOT | | | | | | | | | |
| COMPL | | 4 | Homem | aker | 1 | | | | Home | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | | iddle, Maiden | | | |
| 出 | Abraham Proni 190. INFORMANT'S NAME (Type/Print) | n | | | 1.4 | 2 | | | orkin | | | |
| 2 | Judith Cohen | | | | | | | | | m, State, Zip C | | d 2081 |
| | 20A METHOD OF DISPOSITION | | | | | | | | | | | |
| | 1 Buriel 2 Cremation 3 Re 4 Donation 5 Other (Specify) | | 20b. PLACE AND DATE | | | | 9. | 5-E | 944 | CATION - CH | | ryland |
| | 1 | | | | | | | | | | | Tryrand |
| | | | | | | | | | | | | |
| | Jugan | NO. | Falls Church, Virginia 22046 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approx. | | | | | | | | | |
| | IMMEDIATE CAUSE (Finel disease or condition resulting in death) | CVA wit | th Left | hemi | | | | | | | , | Approximate interval Betwee Onset and Dest 3 Yrs. |
| z | DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| RTIFICATIO | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | c | | | | | | | | | | |
| SAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | DUE TO (OR A | AS A CONSEQUENCE | OF): | deriying | cause g | jiven in Pa | ert I. | 24a, WAS AN PERFO | RMED? | Al CI | MILABLE PRIOR TO OMPLETION OF CAUSE |
| MED | If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR A | AS A CONSEQUENCE | OF): | deriying | g cause g | jiven in Pa | ert I. | | RMED? | AA CO | MILABLE PRIOR TO |
| MEDICAL | If siny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions to the condition of the cause of th | d | AS A CONSEQUENCE | of): | 26. PL | ACE OF D | EATH (Check | only one | PERFO | RMED? | AA CO | MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? |
| SICIAN: MEDICAL | If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions to the condition of the condition of the condition of the cause of the caus | DUE TO (OR A d one contributing to deet HOSPITAL: 1 Inpatient 2 ERVC | h but not resulting | of the und | 26, PL : Ing Hom | ACE OF DI | EATH (Check | only one | PERFORM 1 YES : | RMED? | AA CO OO 1 | MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? |
| BY PHYSICIAN: MEDICAL | If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions of the condition of the condition of the condition of the condition of the condition of the cause of | DUE TO (OR A d Dona contributing to deet HOSPITAL: 1 Inpatient 2 ERVC (Month, Day, Ye. | h but not resulting | OTHER: 4X Aural ME OF JURY M | 26. PL: : Ing Hom 28c. INJ WO 1 1 Y | ACE OF DI | EATH (Check sidence 6 2 | only one | PERFORM (Specify) | RMED? | AN CU OI 1 | MLABLE PRIOR TO METITION OF CAUSE F DEATH? YES 2 NO |
| BY PHYSICIAN: MEDICAL | If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions of the conditions of the conditions of the conditions of the cause of the c | DUE TO (OR A d Dona contributing to deet HOSPITAL: 1 Inpatient 2 ERVC (Month, Day, Ye. | h but not resulting Duripetient 3 DOA RY 26b. Ti | OTHER: 4X Aural ME OF JURY M | 26. PL: : Ing Hom 28c. INJ WO 1 1 Y | ACE OF DI | EATH (Check sidence 6 2 | Other | PERFORM (Specify) | RMED? | AN CU OI 1 | MALABLE PRIOR TO TO TO THE PRIOR TO TO TO THE PRIOR TO TO TO TO TO TO TO TO TO TO TO TO TO |
| BY PHYSICIAN: MEDICAL | If sny, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events resulting in desth) LAST PART II. Other significant conditions and the conditions of the conditions of the conditions of the conditions of the conditions of the cause of the cau | DUE TO (OR A d ona contributing to deet HOSPITAL: 1 Inpatient 2 ER/C 26a. DATE OF INJU (Month, Day, Ye) 26a. PLACE OF INJU | Dutpetient 3 DOA RY 28b. Ti Br) URY — Al home, farm Specify) | OF): | 26. PL: ing Hom 28e. INJ WO 1 Y Try, office | ACE OF DI | EATH (Check sldence 6 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 | Other Bd. DES | PERFOI 1 YES : (Specify) (Specify) TION (Street r Town, State, | INJURY OCCU | AND CIO | MILABLE PRIOR TO MPLETION OF CAUSE F DEATH? YES 2 NO |
| PHYSICIAN: MEDICAL | If sny, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events resulting in desth) LAST PART II. Other significant conditions and the conditions of the conditions of the conditions of the conditions of the conditions of the cause of the cau | DUE TO (OR A d | h but not resulting Dutpetient 3 DOA RY 28b. Ti BY URY — Al home, farm Specify) nowledge, death occur ation and/or investigat | OF): | 26. PL: ing Hom 28e. INJ WO 1 Y Try, office | ACE OF DI | EATH (Check sldence 6 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 | Other I Other II LOCA City of the caure | PERFOI 1 YES : (Specify) (Specify) TION (Street r Town, State, | INJURY OCCUI | RED Rural Rour Cause(a) et signed (M. Sign | OMPLETION OF CAUSE F DEATH? YES 2 NO YES 2 NO |

DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL BECORDS BO BOY 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed writing and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - FOR STATE REGISTRAR | STATE OF M | ARYLAND / | DEPART | MENT OF H | EALTH AND DEATH | MENTAL | HYGIEN REG. NO. | E | | | | | |
|--------------------|--|--|------------------------------|------------------------------|--|---|---------------------|----------------------------------|-------------------------------------|--------------------------|--|-------------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 60-5 | | | | | 2. DATE | OF DEATH | W . | /EAR | 3. TIME OF D | EATN | | |
| | MARY 4. SOCIAL SECURITY NUMBER | GOLD | | LAN | IF UNDER 1 YEAR | IF UNDER 24 HRS. | SEPT | 4,] | 994 | | 6:40 | | | |
| | 214-48-2936 | 5. SEX | 8. AGE (In yrs. las | t birthday) | Dey, Year) | | Country) | | r Foreign | | | | | |
| | 9a. FACILITY NAME (if not institution, give s | 1 2 | 85 | | 9b. CITY, TOWN (| OR LOCATION OF D | | . 20, | 1908 9c. COUNT | | | | | |
| TOR | PICKERSGILL HOME | | | | TOWSO | | | | | LTIN | | | | |
| DIRECTOR | MARYLAND BAI | LTIMORE | | | TOWN OR LOCAT | TION | _ | | | 10d. INSIDE C LIMITS? | | | | |
| AL | 10e. STREET AND NUMBER | | | | 10 | . ZIP CODE | | | 10g. CITIZE | | IAT COUNTRY | | | |
| FUNERAL | 615 CHESTNUT AVE | | | | | 21204 | | | USA | | | | | |
| BY FUI | 11. MARITAL STATUS 1 | 12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WI | YES 2 VA | MED IO | tt yes, sp | ENDENT OF HISPA ecity Cuben, Maxic 2 , NO Speci | an, Puerto R | | or No— 14 | Black, | RACE — American Indian, Black, White, atc. Specify WHITE | | | |
| ED E | 15. DECEDENT'S EDU | ICATION | 16a, DE | CEDENT'S U | SUAL OCCUPATION | 21 DN | 16h | KIND OF BUS | INESS/MICH | | VIII I I | | | |
| COMPLETE | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | (Gi | tve kind of wo Do NOT use | rk done during mo | | | KIND OF BOS | M4E33/14D03 | ,,,,, | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) JOHN | В | JRNS | | | 18. MOTHER'S NA MARY | AME (First, A | liddle, Maiden | | LLAC | SHER | | | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) PICKERSGILL HOME | | 198 | 615 C | ODRESS (Street & | nd Number or Rural AVENUE | Route Numb | or, City or Town | 1, State, Zip C | 04 | | | | |
| | 20a, METHOD OF DISPOSITION 1 Burist 2/ Cremetton 3 Rem 4 Donation 5 Other (Specify) | ioval from State | cemetery, crei | matory or other | DISPOSITION (Ne er place) ERVICE (| | 9/7/9 | | SON, | | n, Stata | | | |
| | 21. SIGNATURE OF SUNERAL SERVICE LA | JOHN I | E. DOLAN | | 22. NAME AI | TOWSON | ACILITY | | | | | | | |
| - | / / - | elan | | | 1050 | YORK RO | AD TO | WSON, | MD. 2 | 1204 | 1 | | | |
| | 23 PART i. Enter the diseases, or shock, or heart fallure. | List only one caus | e on each ilne | ath. Do no | t enter the mo | de of dying, suc | ch as card | iac or respi | ratory arres | 1, | | Imate Between and Death | | |
| - | IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Placetic Carcinoma a. Chief To (OR AS A CONSCIUENCE OD) | | | | | | | | | | | | | |
| | resulting in death) | DUE TO (| OR AS A CONSEC | DUENCE OF | | | | | | | رر | mm C | | |
| NO | Sequentially list conditions, b. Dus to construct on | | | | | | | | | | | | | |
| ATI | Sequentially list conditions, lif any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| ERT | resulting in death) LAST | d | | | | | | | | | | | | |
| | PART II. Other algolificant condition | s contributing to | feath but not re | eaulting in | the underlying | causa givan in | Pert I. | 24a, WAS AN | | 24b. ¥ | VERE AUTOPS | Y FINDINGS | | |
| PHYSICIAN: MEDICAL | | | | | | | | PERFOR | | 0 | MAILABLE PRICOMPLETION OF DEATH? | | | |
| ME | | | | | | | | | | | YES 2 | □ NO | | |
| Z | DID TOBACCO USE CONT | RIBUTE TO CAL | | | | UNCERTAI | N 🗆 | | | | | | | |
| S | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | _ (| (Check only one) | | | | | | | | | |
| HYS | 27. MANNER OF DEATH | 1 Inpatient 2 28e. DATE OF II | NJURY | 28b. TIME | OF 28c. tNJ | 5 Residence | _ | (Specify) | JURY OCCUI | RED | | | | |
| ВУ Р | 1 Natural 5 Pending | (Month, Day | r, Year) | INJUF | RY WO | RK? ES 2 NO | | | | | | | | |
| | 2 Accident Investigation 3 Suictde 6 Could not be determined | 28e. PLACE OF building, e | INJURY — At horte. (Specify) | me, term, str | eet, tactory, office | | 28f. LOCA City o | TION (Street a r Yown, State) | nd Number or | Rural Roo | ute Number, | | | |
| COMPLETED | 1-1 | ICIAN: To the best of n | | | | | | | | | | | | |
| 8 | 2 MEDICAL EXAMINE | IR: On the beels of exe | mination and/or in | nvestigation, | In my opinion, d | | | and place, end | due to the o | ause(e) e | end manner a | e stated. | | |
| TO BE | 29h. SHOWAT WHE SHO TITLE CENTRAL | ly, | 2 | D 2 5 20 5 | | | | | 29d. DATE SIGNED (Month, Day, Year) | | | | | |
| | 30. NAME AND ADDRESS OF PERSON WN | O COMPLETED CAUSE | G B | 27) (Type, P | rint) | | | | - | | | | | |
| | SEP 0 8 199 | 32. BAGISTRAR | 'S SIGNATURE | delle | | | | | | | | | | |

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AND 21215-0020

TAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be hours after death with the State Dept. of Health and Merital Hygiene prior to builal, cremation, or remond.

| | B.K.S | | | | | 74 | 20000 |
|---|--|---|------------------------|-------------------------------------|---------------------|--------------------------|---|
| | | | | | | | |
| | FOR 1 - STATE | STATE OF MARYLAND / | | | | | |
| | REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) | CE | HITICALE | OF DEATH | 2. DATE OF D | G. NO. | 3. TIME OF DEATH |
| | RABAR | RASUAL M | OORE | | SEPT. | | 10:35 Am |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 8. AGE (In yrs. last | t birthday) IF UNDER | 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BI | RTH 8. | BIRTHPLACE (State or Foreign |
| | 213-98-3343 | 1 2 1 F 2/ | YRS. MONTHS | DAYS HOURS MIN. | (Month, Day. | -72 | nary pro |
| 1 | 9s. FACILITY NAME (If not institution, give street | | 9b. CITY | TOWN OR LOCATION OF C | DEATN | 9c. COUNTY | OF DEATH |
| 6 | 631 NORTH FULT | ON AVENUE | BAI | TIMORE CI | TY | | |
| DIRECTOR | 10s. STATE 10b. COUNTY | | 10c. CITY TOWN C | OR LOCATION | | - | 10d. INSIDE CITY |
| 1 2 | Maryland | | BAL | imore | | | LIMITS? |
| A AL | 10e. STREET AND NUMBER | 1 | | 10f. ZIP CODE | 10 | 10g. CITIZEN | OF WHAT COUNTRY? |
| FUNERAL | 11. MARITAL STATUS | on fue | | 10/21 | // | u. | 1514 |
| | I I DE MOTTION 2 MOTTION | I2. WAS DECEDENT EVER IN U.S. ARI FORCES? 1 ☐ YES 2 ☐ N IF YES, GIVE WAR OR DATES | 10 | WAS DECENDENT OF NISPA | an, Puarto Rican, | | . RACE — American Indian, Black, While, slc. |
| ğ | | eserve | | 1 TYES 2 PMO Speci | my: | | BIACK |
| TED | 15. OECEDENT'S EDUCA' (Specify only highest grade co | TION 18s. DE | CEDENT'S USUAL Of | CCUPATION during most of working | 16b. KIND | OF BUSINESS/INDUS | TRY |
| once. | Elementary/Secondary (0-12) | College (1-4 or 5+) | Op NOT use retired.) | (1) miles | | Ent | |
| OM O | 17. FATHER'S NAME (First, Middle, Last) | | 113110 | 18. MOTNER'S N | AME (First, Middle, | Maiden Surremed | 7 |
| E S | 74/14 | moore | | SACAL | 1. | AU | Tru |
| TO B | 196. INFORMANT'S NAME (Type/Pyrit) | G 191 | MAILINO ADDRESS | (Street and Number of Rural | | y or Town, State, Zip Co | de) (j |
| 2 - | Mrs. JAcquelin | e moore | 23/11 | Hullow | AULI | BAITO. | md. 21217 |
| 15 | 20a. M57HOD OF DISPOSITION 1 Buriel 2 Cremation 3 Ramove | al from Stata 20b. PLACEA | NE DATE OF DISPOS | TION (Name of | 19/2 | 20c. LOCATION -City | or Town State |
| E | 4 Onetion 5 Other (Specify) | ISEE. | 221 | NAME AND ADDRESS/OF F | CIVOY CO | 13/11/0 | (or In a |
| examiner must be notified at once. TO BE COM | Jensoch 1 | Dunal | te | sephhil | CUSS! | JUNE, | My your |
| <u>ea</u> | 23. PART I. Enter tha diseasea, or con | molications that caused the de | 2/ ath Do ant anto | 202 10.11 | DID F | We KOA | 110.mor21216 |
| other traumatic event, the medical | ahock, or heart failure. Lis | at only one cause on each line. | atii. Do not antar | tha moda or dying, aut | on as cardiac o | r reapiratory arrest | Interval Between |
| 흎 | IMMEDIATE CAUSE (Final disease or condition | Gunshat w | 200 | 1 alala | | | Onset and Death |
| yent | resulting In death) a. | DUE TO (OR AS A CONSEC | DUENCE OF): | ar eron | | | |
| S S | Sequentially list conditions, b. | | | | | | |
| her traumal | If any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A CONSEC | OUENCE DF): | | | | |
| 필임 | CAUSE (Disease or Injury | DUE TO (OR AS A CONSEC | UENCE OF): | | | | |
| - I DE | resulting in death) LAST | | | | | | |
| Injury, o | PART II. Other aignificant conditions | contributing to death but not re | esulting in the un | deriving cause given in | Port I 24n | WAS AN AUTOPSY | 24b, WERE AUTOPSY FINDINGS |
| ws any in EDICAL | | | and the art | autymig cadac givanii | | PERFORMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| WS a | | | | | 1 32 | YES 2 NO | OF DEATH? 1 (2) YES 2 □ NO |
| shows Z: MEC | DID TOBACCO USE CONTRI | BUTE TO CAUSE OF DEA | TH YES 1 | NO UNCERTAL | NΠ | | 1 DY YES 2 NO |
| Item 23 s | 25. WAS CASE REFERRED TO MEDICAL | 28. PLAC | E OF DEATH (Check | only one) | | | |
| | 1XXES 2 □ NO | OSPITAL: | □ DOA 4 □ Num | aing Home XXIssidencs | 8 Other (Spe | cify) | |
| A E | 27. MANNER OF DEATH 1 Natural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | | NOW INJURY OCCUR | ED |
| | 2 Accident Investigation | 9/2/94 28a. PLACE OF INJURY — At hor | 1035 M | 1 VES 2 NO | | CT SHOT | Burst Courts At Labor |
| 28 is TED | 4 Homicide 8 Could not be detarmined | building, atc. (Specify) | OME | , | City or Tow | | AUE, BALTIMORE |
| Item 2 PLET | 29s. CERTIFIER (Check only | IN: To the beat of my knowledgs, dar | | me, data and place, and due | | | MUE, UMLI IMURE |
| MPDRTANT: If item D BE COMPLE | | On the basis of examination and/or is | | | | | suse(a) and manner as stated. |
| E CC | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | 29c. LICENSE NU | MBER | 29d. OATE SI | GNED (Month, Day, Year) |
| B B | Nonald 411) | right MD | | 0.C.1 | М.Е | | T. 3,1994 |
| ΠĔ | 30. NAME AND ADDRESS OF PERSON WHO O | COMPLETED CAUSE OF DEATH (ITEA | 1 27) (Time Print) | | | | |

ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Of WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201

32. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| | permit. Pages 1, 2, 3 should | | | |
|--|---|---|---|--|
| ICIAN: The law requires that the death certificate be executed within chours after these first be retained by the hospital or attending physician. | Interpret has been signed by the attending physician and completely filled in by 🕪 furners in ector, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 st | | 6 | |
| ay be retained by the t | page 5 should be deta | | ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
| after death. Page 6 m | by the funeral director, | Toval. | cal examiner must | |
| cuted within hours | I completely filled in t | urial, cremation, or re- | ic event, the medi | |
| eath certificate be exec | attending physician and | ntal Hygiene prior to be | y, or other traumat | |
| aw requires that the de | s been signed by the | the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal | 3 shows any injury | |
| ING PHYSICIAN: The I | 20 | - | marked, or item 2 | |
| TO THE HOSPITAL OR ATTENDING PHYSIC | D THE FUNERAL DIRECTOR; After this of | be filed within 72 hours after death with | MPORTANT: If item 28 is marked | |
| TO THE H | TO THE FI | be filed w | IMPORT | |

STATE OF MARYLAND 7 DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR 1 - STATE

| | REGISTRAR | | CERTIFI | CATE C | F DEATH | | REG. N | O. | | |
|---------------|--|---|-----------------------------------|---------------------------|--|---------------|--------------------------------|----------------|-------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DAT | E OF DEATH | DAY | YEAR | 3. TIME OF DEATH |
| | George Moy | | | | | | | 3 - | 94 | 5:20 A M |
| | 4. SOCIAL SECURITY NUMBER 5. SE | | In yrs, last birthday) | IF UNDER 1 YE | | RS. 7. DAT | E OF BIRTH | | S. BIRTH | HPLACE (State or Foreign |
| | | (M2□F 5 | 9 YRS. | | 100 | | 1/35 Year) | | BAL | TIMORE CO. |
| oc | 9e. FACILITY NAME (If not institution, give street end | d number) | | 96. CITY, TOV | N OR LOCATION O | F DEATH | | 200 | NTY OF D | |
| ᅙ | G.B.M.C. | | | | | | |] B | ALTIM | UKE |
| DIRECTOR | 10a. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LO | CATION | | | | | 10d. INSIDE CITY |
| <u> </u> | MARYLAND BALTIMORE | | PH | DENIX | | | | | | LIMITS? |
| ¥ | 10e. STREET AND NUMBER | | | | 101. ZIP CODE | | | 10g. CIT | IZEN OF V | WHAT COUNTRY? |
| 띨 | 3526 SWEET AIR ROAD | | | | 21131 | | | | USA | |
| FUNERAL | 11. MARITAL STATUS 12. W | AS OECEDENT EVER IN DRCES? 1 YES | U.S. ARMED | | DECENDENT OF HIS specify, Cuben, Me | | | es or No- | 14. RACE Black | E American Indian, k, White, alc. |
| à l | 3 Widowed 4 Divorced | YES, GIVE WAR OR OF | ITES | 1 🗆 | res 2 No S | pecify: | | | Speci | |
| | 15. DECEDENT'S EQUICATION | | 16a. DECEDENT'S U | SUAL OCCUP | ATION | 16 | b. KIND OF B | USINESS/IN | DUSTRY | IC. |
| | (Specify only highest grade complete Elementary/Secondery (0-12) Colle | red) ege (1-4 or 5+) | (Give kind of we life. Do NOT use | ork done during | most of working | 1 2 | | 001112007111 | | |
| 린 | 10 | | AUTO PARTS | S SALES | 1AN | | CITY OF | IEVROLE | T | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Lest) | | | | IS. MOTHER'S | S NAME (First | Middle, Malde | n Sumame) | | |
| BE | HAROLD MOYER | | | | SELMA | WEBBEF | } | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | et and Number or R | | | | p Code) | |
| | ROBERT MOYER | | | | R RD. BAL | | _ | | | |
| | 20a METHOD OF DISPOSITION 1 A Burtal 2 Cremation 3 Removal fro | State 20b. | PLACE AND DATE OF | FDISPOSITION AV place) | (Name of | | TE 20c. L | | | |
| | 4 Donation 5 Other (Specify) 21. SIGNATIFIE OF FUNERAL SERVICE LICENSEE | | A110/00D CLI | | AND ADDRESS OF | | A DF | IL I II ION | L, NO | |
| - 1 | Kansahatin | and blace | ~~ | LAS | SAHN FUNER | AL HOME | | | | |
| \dashv | 22 PART I Stier the disease or small | an un | 11/2 | 740: | L BELATR R | D. BAL | TIMORE, | MD. 2 | 1236 | |
| | 23. PART I. Enter the diseases, or complice shock, or heart failure. List on | callons that caused ily ona causa on a | the death. Do no ach lina. | t enter the | mode of dying, | auch aa ca | rdiec or res | piratory er | real, | Approximate Interval Batween |
| | IMMEDIATE CAUSE (Final diagase or condition | 110000 | | | | | | | | Onset and Death |
| 1 | resulting in death) a | LISSAT F | CONSEQUENCE OF | | | | | | | |
| _ | | AURTIC | , | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF | ממניט | 7)= | | | | | |
| S | CAUSE (Disease or Injury | | FAILL | | | | | | | |
| | that initiated events resulting in death) LAST | | CONSEQUENCE OF | * | | | | | | |
| | d. | 0123 | 5 165 | | | | | | | |
| | PART II. Other significant conditions confi | ributing to death be | ut not resulting in | tha underl | ying cause giver | ı in Part t. | | N AUTOPSY | 24b | WERE AUTOPSY FINDINGS |
| DICAL | | | | | | | | 2 DINO | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEC | | | | | | | | L | | OF DEATH? 1 YES 2 NO |
| ż | DID TOBACCO USE CON | TRIBUTE TO | CAUSE OF | DEATH | YES | 40 🗆 | | | | |
| CIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | PITAL: | | | PLACE OF DEATH | (Check only | one) | | | |
| | 1 YES 2 1 NO 1 1 1 | patient 2 ER/Outp | | OTHER: 4 - Nursing I | iome 5 🗆 Realder | nce 6 🗆 Ott | ner (Specify) | | | |
| PHYS | 27. MANNER OF DEATH 2 | (Month, Day, Year) | 28b. TIME INJU | RY | INJURY AT WORK? | 1 | EȘCRIBE HOW | INJURY OC | CURED | |
| ⋒ | 2 Accident Investigation | | | | YES 2 NO | | | | | |
| | 3 Suicide S Could not be 4 Homicide determined | Sa. PLACE OF INJURY building, alc. (Spec | - At home, farm, st | reet, factory, o | iffica | | CATION (Streety or Town, State | | r or Rural F | Route Number, |
| COMPLETE | 29a, CERTIFIER | | | | | | | | | |
| <u>F</u> | (Check only one) 2 MEDICAL EXAMINER: On III | | | | | | | | | |
| 8 | 2%. SIGNATURE AND TITLE OF CERTIFIER | | T STOLOG TIVE BLIGHT (OT | , in my opinio | | | ta and place, | | | |
| # | STATIONE AND TITLE OF CENTIFIER | | | | 29c. LICENSE | | | | E SIGNED | (Month, Day, Year) |
| 2 | 30 NAME AND ADDRESS OF PERSON WHO COMP | PLETED CAUSE OF DE | ATH (ITEM 27) /Type: 1 | Print) | 0/936 | 7-1 | | | יינויי | / |
| | JAMES HMERSE | | 5 No C 14. | | FT As | A. A. | 2/14 | | | |
| | 31. DATE FILED (Month, Day, Year) / 3 | 2. REGISTRAR'S SIGN | ATURE | | | -1/1-6 | | | | |
| | SEP 0 8 1994 5-1 | Deniem-Ru | Jail. | | | | | | | |

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| DIVISION OF VITAL RECORDS, | |
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TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within and not share death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Debt. of Health and Memtal Hyglene prior to burial, committing. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Alfonso

Valle,

(Month, Day, Year) 0 8 1994

M.D.

| | | | | | | | | | | | | 74 | 20 | 500 |
|--------------|--|--------------|-----------------------------|--|---------------------------|-------------|---------------|---------------------|-----------------------|------------|-----------------------|--------------|-------------------|--|
| | 1 - FOR STATE REGISTRAR | | STATE OF N | | DEPAR | | | | | MENT/ | AL HYGIEN REG. NO. | E | | |
| | 1. DECEDENT'S NAME (First, Middle | , Last) | | | | | | | | | E OF DEATH | | 3 | . TIME OF DEATH |
| | Ronald E | luge | ne Mu | llins | | | | | | Sen | tembe | | YEAR 1994 | 8:36A M |
| | 4. SOCIAL SECURITY NUMBER | 1 | S. SEX | 6. AGE (In yrs. Id | st birthday) | | ER 1 YEAR | IF UNDER | 24 HRS. | 7. DATE | E OF BIRTH | | 8. BIRTHPL | ACE (State or Foreign |
| | 228-46-8724 | - 1 | 1 □XM 2 □ F | 56 | YRS. | MONTHS | DAYS | HOURS | MIN. | | oth, Day, Year) | 937 | Country) | ginia |
| | 9a. FACILITY NAME (If not institution | , give stree | et and number) | | | 9b. CIT | Y, TOWN | OR LOCATI | | | | | TY OF DEA | |
| DIRECTOR | Prince Georg | es | Doctor | s Hosp | ital | | L | anha | n | _ | | Prin | ce G | eorges |
| Ä | 10e. STATE 10b. C | COUNTY | | | 10c. CIT | Y, TOWN | OR LOCAT | TION | | | | | 19 | Dd. INSIDE CITY |
| 5 | Maryland Pr | inc | e Geor | aes | Se | abr | ook | | | | | | 1 | LIMITS? |
| AL | 104. STREET AND NUMBER | | | | | 0.70 | - | . ZIP COD | E | | | 10g. CITIZ | | AT COUNTRY? |
| FUNERAL | 6804 99th A | ven | ue | | | | | 2 | 2070 | 6 | | | U.S. | Δ |
| S | 11. MARITAL STATUS | | 12. WAS DECEDEN | | | 13 | . WAS DEC | | | | IN? (Specify Yea | | _ | |
| | 1 Never Merried 2 X Married | d | FORCES? 1 IF YES, GIVE W | Y YES 2 T | NO | | If yes, sp | ecify Cuba | n, Mexicar Specify | , Puerto | Rican, atc.) | | Black, \ Specify: | - American Indian, Vhita, atc. |
| ВУ | 3 Widowed 4 Divorced | | | | | | | - 11 110 | Opedity | | | | Зриспу | white |
| | 15. DECEDENT (Specify only highes | | | 16a. D | ECEDENT'S Sive kind of | USUAL (| OCCUPATIO | ON of of working | | 16 | b. KIND OF BUS | INESS/IND | ISTRY | |
| | Elementary/Secondary (0-12) | 1 | College (1-4 or 5 + | 1/6 | Do NOT u | se retired. |) | SI UF WUFKI | ·V | | | | | |
| MP | | | 1 | Co | mput | er | Pro | gram | nmer | | Sheet | Met | al U | nion |
| COMPLETED | 17. FATHER'S NAME (First, Middle, La | nst) | | | | | | 16. MOTI | HER'S NAI | AE (First, | Middle, Maiden | Surname) | | |
| BE | Unavailable | Mul | lins | | | | | Jes | sie | Mu | llins | | | |
| 10 | 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | | | | |
| - | Dorothea Mullins 6804 99th Avenue, Seabrook, Md. 20706 | | | | | | | | | | | | | |
| | 20a, METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 | Roman | al from Ctate | 20b. PLACE | AND DATE | OF DISPO | SITION (Na | | | DA | | CATION — C | | , State |
| | 4 Donation 5 Other (Specify) National Mem. Park 9-7-94 Falls Church, Va | | | | | | | | | | ch.Va. | | | |
| | 21. SIGNATURE OF FUNERAL SERV | ICE LICEN | ISEE . | | | 22 | NAME AL | ID ADDRE | SS OF FAC | UL ITY | | | | |
| | Ives-Pearson Indiana | | | | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | | | | |
| | ehock, or heart fe | llure. Lie | et only one cau | se on each iin | е. | TOT WITH | i dio illo | ua bi uyi | ing, oder | as car | unic or respi | atory arre | rat, | interval Batween |
| | IMMEDIATE CAUSE (Fine) | | 0 | | | | | | | | | | | Onset and Death |
| | resulting in death) | 0, | | onary | | | als | ease | 2 | | | | | - |
| - | | _ | | DUE TO (OR AS A CONSEQUENCE OF): Hypertensive arteriosclerotic cardio- | | | | | | | | | | |
| ERTIFICATION | Sequentially liet conditions, | b | пурет | OR AS A CONSE | OUENCE O | ter | 105 | cier | otl | C C | ard10 | _ | | |
| Ϋ́ | if any, leading to immediate cause. Enter UNDERLYING | | | | | , | | | 7725 | C11 1 | ar dis | 5025 | _ | j |
| Ĕ | CAUSE (Disease or injury that initieted events | 6. | DUE TO | OR AS A CONSE | OUENCE O | F): | | | Vas | cui | ar ar. | seas | | |
| 듄 | resulting in death) LAST | | | | | | | | | | | | | |
| 2 | DART II ON 1 10 | | | | | | | | | | | | | |
| MEDICAL | PART II. Other eignificent con | ditions | contributing to | death but not | recuiting | in tha u | inderlying | cenee 6 | given in I | Pert I. | 24s, WAS AN PERFOR | | | ERE AUTOPSY FINDINGS WILABLE PRIOR TO |
| ă | | | | | | | | | | _ | 1 _ YES 27 | NO E | | OMPLETION OF CAUSE F DEATH? |
| ٣ | | | | | | | | | | | | | | YES 2 NO |
| ä | DID TOBACCO USE CO | ONTRI | BUTE TO CA | USE OF DEA | ATH YE | S 🗆 | NO [| UNC | ERTAIN | | | | | |
| 8 | 25. WAS CASE REFERRED TO MEDIC EXAMINER? | | 10cpital - | 28. PLA | CE OF DEA | | | | | | | | | |
| S | 1 TES 2 XNO | | IOSPITAL: ☐ Inpatient 2 | ER/Outpatient | DOA | OTHE | | e 5 🗆 Re | sidence (| B □ Oth | er (Specify) | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | | 28a. DATE OF (Month, Da | | 28b. TIM | IE OF | 28c. INJ | URY AT | | 28d. DE | SCRIBE HOW IN | JURY OCC | JRED | |
| ВУ | 1 Netural 5 Pending 2 Accident Investig | | | | | М | 1 🗆 1 | | NO . | | | | | |
| | 3 Suicide 8 Could n | | 28e. PLACE Of building, | FINJURY — At he | ome, ferm, | street, tec | ctory, office | | | | CATION (Street a | nd Number o | or Rural Rou | a Number, |
| | 4 Homicide detarmin | ned | | | <u>.</u> | | | | | Oily | rown, state) | | | |
| 1 | 29a. CERTIFIER Check only | PHYSICIA | N: To the best of | my knowledge, d | eth occurr | ed at the | time, deta | and place, | and due t | to the ca | use(a) end man | ner aa state | d. | |
| COMPLETED | 000) | | | | | | | | | | | | | nd manner es stated. |
| / \ | | | | | | | | | | | | | | |

29c. LICENSE NUMBER

D12879

Trafton Dr., Largo, Md.

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

10701

DHMH-16 Rev 1/89

29d. DATE SIGNED (Month, Day, Year)

20772

Sept.3,1994

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BALTIMORE, MARYLAND 21215-0020

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DIRECTOR

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CERTIFICATION

MEDICAL any

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31. DATE THE MAN IN BOY! BOY +

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STEUENSON

39. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Ve

32 REGISTRARIE CHENT HUDE

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

OR ATTENDING PHYSICIAN

| | it permit. Pag | |
|--|--|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit be find within 70 hours after death with the State hear of Health and Mental Huniene note in burial cremation or removal | |
| al or attendir | for use as the | |
| by the hospit | be detached | at once. |
| be retained | age 5 should | be notified |
| . Раде 6 тау | al director, p | iner must |
| rs after death | removal | IMPORTANT: If them 28 is marked, or them 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| this hou | etely filled in | it, the me |
| executed wi | n and complete | matic ever |
| certificate be | ding physicia | other trau |
| at the death | by the atten | y injury, or |
| w requires th | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the face within 72 hours after death with the State Den' of Health and Mental Homens prior in burial cremation or remova- | shows an |
| CIAN: The lan | rtificate has | or Item 23 |
| DING PHYSIC | After this ce | s marked, |
| L OR ATTEN | DIRECTOR: | Item 28 is |
| HE HOSPITAL | HE FUNERAL | ORTANT: 11 |
| 101 | 2 2 | MP |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1027 YEAR JOSEPH MARKER SEPTEMBER 1994 4. SOCIAL SECURITY NUMBER 5 SEY 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1917 Brooklyn
Sc. COUNTY OF DEATH W YOLK DAYS Dec. 10, 055 07 8133 17€7XM 2 □ F 76 YRS. 9e. FACILITY NAME (If not institution, give street and nu 9b. CITY, TOWN OR LOCATION OF DEATH Suburban Hospital Bethesda Montgomery RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Bethesda 1 YES 2 XXO Maryland Montgomery 10f. ZIP CODE 10a CITIZEN OF WHAT COUNTRY? 7425 Democracy Blvd., #208
MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 20815 United States 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 14. RACE — American Indian 1 Never Married 2 Married FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES Caucasian 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Small Business Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Attorney Administration 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillie Silverman William Marker 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hannah Marker Same address as #10 20s. METHOD OF DISPOSITION
14 Surfal 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) Septe 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of Rockville, Md. Menorah Gardens 21. SIGHAYURA DE FUNERAL SERVICES ICENSER 22, NAME AND ADDRESS OF FACILITY Ives-Pearson Funeral Homes Falls Church, Virginia 22046 23. PART | Entar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart failure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in dasth) SEVERE CEREBRAL ANOWA 36 HR DUE TO (OR AS A CONSEQUENCE OF): OUT IF HOSPITAL CARDIAC ARREST Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if sny, lasding to immediate cause. Enter UNDERLYING ISCHEMIC CARDIOMYOPATHY CAUSE (Disesse or injury that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO Accident Investigation 28e. PLACE OF INJURY — Al home, tarm, street, factory, office building, atc. (Specify) 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City, or Town, State) 8 Could not be determined 4 🗌 Homicide 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date and place, end due to the ceuse(a) and manner ea stated. MEDICAL EXAMINER: On the beals of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. 296 SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER

6410 ROCKLEDGE DR. #200

| NOING PHYSICIAN: The law requires that the death certificate be executed with: nours after death cleath. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hydiene prior to bunal, cremation, or removal. | is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
|---|---|--|--|
| TO THE MOSPITAL OR ATTENDING PHYSICIAN: TH | TO THE FUNERAL DIRECTOR: After this certificate be filed within 72 hours after death with the State | IMPORTANT: If item 28 is marked, or iten | |

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | | CERTIF | ICALE | OF | DEATH | | REG. NO. | | | |
|------------------|--|------------------------------|-------------------------------|------------------------------------|--------------------------------------|--------------------|-------------------------------------|---------------|-----------------------|---------------|--------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATI | OF DEATH | | | 3. TIME OF DEATH |
| | MARION MILLER | MCALL | | | | | | MONT | "- 💍 | - 4 | 94" | 4:25 Am |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. | last birthday) | IF UNDER | PAR 1 | IF UNDER 24 HRS | 5. 7. DATE | OF BIRTH | _ | 8. BIRTH | IPLACE (State or Foreign |
| | 101 000707 | 1 - M 2 X F | 0.0 | YRS. | MONTHS | DAYS | HOURS MIN | (Mon | th, Day, Year) | | Countr | y) |
| | 181-262767 9a. FACILITY NAME (If not Institution, give s | | 86 | | | | | | /8/07 | | PA. | |
| ~ | | | | | 9b. CITY, | | OR LOCATION OF | DEATH | | 9c. COU | INTY OF D | |
| <u> </u> | Stella Maris Hosp | ice | | | | lov | /son | | | | Bal | timore |
| <u> </u> | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | , | | 1 40. 00 | | | | | | | | |
| <u>E</u> | | | | | Y, TOWN O | R LOCAL | ION | | | | | 10d. INSIDE CITY LIMITS? |
| 9 | Md. Baltimore Towson | | | | | | | | | | | t 🗌 YES 2 📈 NO |
| ₹ | 10e. STREET AND NUMBER | | | | | 101 | . ZIP CODE | | | | | VHAT COUNTRY? |
| FUNERAL DIRECTOR | 7925 York Rd. | | | | | | 21204 | | | U | JSA | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT | | | t3. W | AS DEC | ENDENT OF HIS | PANIC ORIGI | N? (Specify Yes | or No- | 14, RACE | E — Americen Indien, k, White, etc. |
| | 1 Never Merried 2 Merried | FORCES? 1 IF YES, OIVE W | | X MO | lf 1 | yes, sp | XX NO So | dcen, Puerto | Rican, etc.) | | Speci | |
| BY | 3 X Widowed 4 Divorced | | | | | | | , | | | Ороса | White |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | CATION | 16a. | DECEDENT'S | USUAL OC | CUPATIO | ON | 18 | . KIND OF BUS | INESS/IN | DUSTRY | |
| E | Elementery/Secondary (0-t2) | College (1-4 or 5 + | | (Give kind of a life. Do NOT us | work done di se retired .) | uring mo | st of working | | | | | |
| 립 | 13 | 4 | | Editor | | | | - 1 - | Holt Pu | hlie | hina | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | <u>- 41 001</u> | | | IS MOTHER'S | | Middle, Meiden | | птпд | |
| | Casper Alvirus M | illon | | | | | | | | Surname) | | |
| BE | 19e, INFORMANT'S NAME (Type/Print) | TITEL. | - | 404 400 11 11 10 | | | Eva Cl | | | | | |
| 2 | | | | 19b. MAILING | ADDRESS | (Street e | nd Number or Ru Apt2B Ve. Ba. | rel Route Nun | ber, City or Town | n, State, Zij | p Code) | |
| 1 | Aimee Miller | | | 6122 F | airde | el A | WE. Ba. | ltimor | | | | |
| | 20e. METHOD OF DISPOSITION 1 ☐ Burlel 2 ☑ Cremetion 3 ☐ Reme | oval from State | | crematory or o | | TION (Na | | DAT | | | City or To | |
| | 4 Donetion 5 Other (Specify) | | Metr | o Crem | atory | | inc 9/ | /3/94 | Balt | imor | e, M | d. |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | | 22. N | AME AN | D ADDRESS OF | FACILITY I | lome | | | |
| | # Hoodha L | A low | hom | | | | | | | | | |
| | 22 PART I Enter the disease | MONE | M. K | - | 1/4 | 10T | Belair | Rd. E | Baltimo | re, | Md. | 21236 |
| | 23. PART i. Enter the diseases, or canada ahock, or haert failure. | List only one ceu | se on sech i | ina. | not enter t | the mo | de of dying, s | uch aa car | diac or respi | ratory ar | reat, | Approximate Interval Between |
| | IMMEDIATE CAUSE (Final | | | | | | | | | | | Onaet and Death |
| | disease or condition resulting in death) | THYR | (D) (D) | CAT | VCE | R | | | | | | 76mas |
| | | | OR AS A CON | | | | | | | | | |
| z | | h. | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (| OR AS A CON | SEOUENCE OF | F): | | | | | | | |
| 3 | cause. Enter UNDERLYING | P | | | | | | | | | | |
| Ē | CAUSE (Disesse or Injury that initiated events | DUE TO (| OR AS A CON | SEQUENCE OF | F): | | | | | | | |
| 2 | resulting in deeth) LAST | d | | | | | | | | | | |
| 2 | | | | | | | | | | | | |
| EDICAL | PART II. Other significant condition | a contributing to | death but no | ot resulting i | In the unc | derlying | g causa givan | In Part I. | 24e. WAS AN PERFOR | | 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| 2 | | | | | | | | | 1 YES 2 | | | COMPLETION OF CAUSE OF DEATH? |
| | | | | | | | | | | | | t YES 2 NO |
| - | DID TOBACCO USE O | CONTRIBUTE | TO CA | LICE OF | DEAT | u v | EC CO N | 10. [| | | | |
| ₹ | 25. WAS CASE REFERRED TO MEDICAL | CITIKIDOIL | TO CA | USE OI | PLAII | | ACE OF DEATH | Check only o | nel | | | |
| PHYSICIAN: M | EXAMINER? | HOSPITAL: | EB/Outrott | 2 7 224 | OTHER | : | | | | *** | | |
| ž∥ | 27. MANNER OF DEATH | 28e. DATE OF | | 28b. TIM | | ng Hom 28c, INJ | ● 5 ☐ Residence | 1 | | Hos | | |
| | 1 Natural 5 Pending | (Month, Da | y, 16er) | | URY | WO | RK? | 28G. DE | SCRIBE HOW II | NJURY OC | CURED | |
| ă | 2 Accident Investigation | 40 00 100 00 | | | | | YES 2 NO | | | | | |
| | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF building, e | injury — At otc. (Specify) | home, ferm, a | street, lecto | ry, office | | 281. LOC | Or Town, State) | nd Numbe | r or Rural F | Route Number, |
| 5 N | | | | | | | | | | | | |
| COMPLET | 29e. CERTIFIER CERTIFYINO PHYSI | CIAN: To the beet of a | my knowledge, | death occurre | ed at the tin | ne, date | end piece, and d | fue to the ca | use(e) end men | ner es sta | ted. | |
| 2 | One) 2 MEDICAL EXAMINE | | | | | | | | | | |) and menner se stated. |
| - 11 | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | | | | | | |
| B | *2.d-00 P1 | 20.06 | | | | | 29c. LICENSE N | TUMBER | | 29d. DAT | SIGNED | (Month, Day, Year) |
| 2 | 7 malallin | week | rein | $\mathcal{O}_{\underline{}}$ | | | 000 | 043 | | | 1070 | 14 |
| - | 30. NAME AND ADDRESS OF PERSON WHO | O COMPLETED CAUS | E OF DEATH (I | TEM 27) (Type, | Print) | | | | | | | |
| | DR. KENDALL FAUL | KNER. MD | 2300 | DULAN | IEY V | ALLI | EY RD., | TOWS | ON, MD | 212 | 204 | |
| | SEP 0 8 1994 | | R'S SIGNATURI | E | | | | | | | | |
| | SET U & 1334 | Juli Dani | un-for | we | | | | | | | | |
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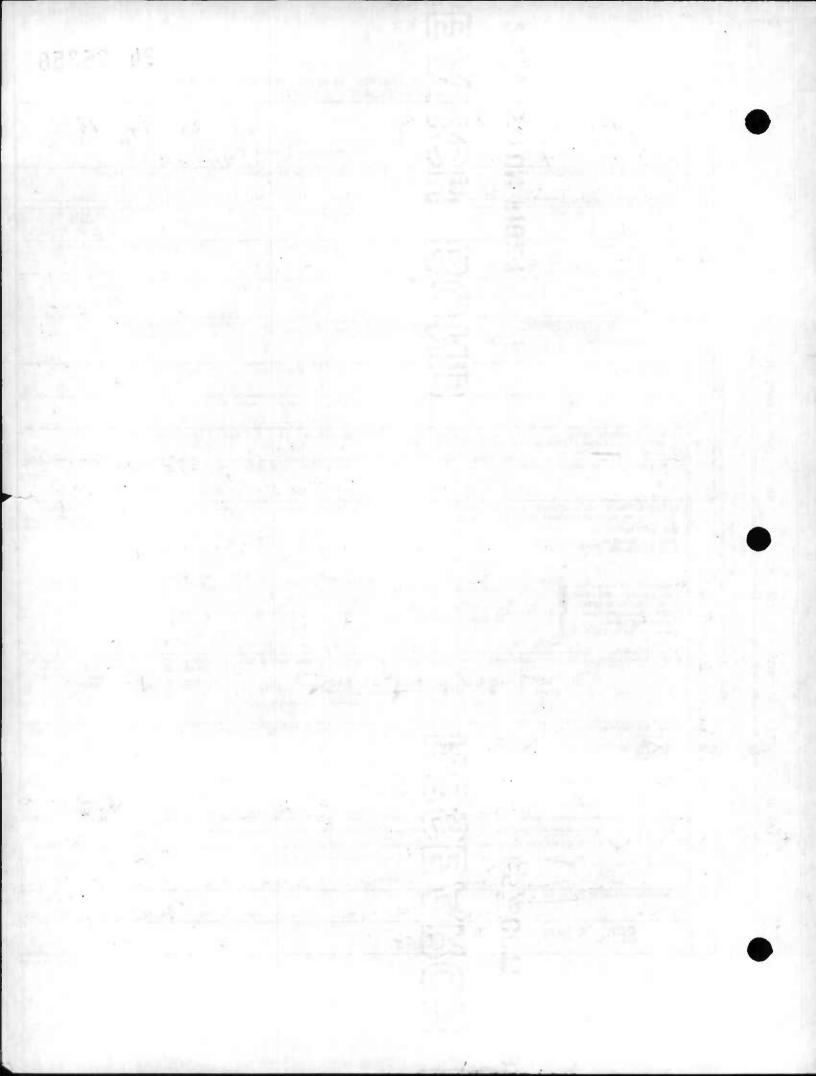
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely lined in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be find within 72 hours after death with the State Deor of Health and Mental Hydiene prior to burial, cremation, or removal.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR PER F. H. G-720 STATE 2/14/95 reb STATE 0F MARYLAND / DEPARTMENT OF HEALT OF MARYLAND / DEPARTMENT OF MARYLAND STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | CERTIFIC | CATE OF DEATH | REG. NO. | | | | | | |
|---------------|--|--|---|--|---|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Brenda V. | Myers | | 2. DATE OF DEATH DAY | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 332-26-79041□ M 2 1 | 100 m | F UNDER 1 YEAR IF UNDER 24 HRS. ONTHS DAYS HOURS MIN. | 7. DATE OF BIRTN (Month, Day, Year); 7/13/22 | 8. BIRTNPLACE (State or Foreign Country) | | | | | |
| TOR | 96. FACILITY NAME (If not institution, give street and number) Washington Alventist Hosp Takoma Park Mont. RESIDENCE OF DECEDENT | | | | | | | | | |
| DIRECTOR | 100. STATE 10b. COUNTY MARY/and PRINCE GEORGE: | | TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? 1 XX YES 2 NO | | | | | |
| FUNERAL | 100. STREET AND NUMBER 4th Ave \$202 101. ZIP CODE 207 83 109. CITIZEN OF WHA | | | | | | | | | |
| BY | Vivora married 5 married | | | | | | | | | |
| LETED | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or | 5+) life. Do NOT use | rk done during most of working | 16b. KIND OF BUSINESS | | | | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | PAULINSTRAT | | | | | | | | |
| BE | BERNARD MYERS | | | MOTNER'S NAME (First, Middle, Meiden Surneme) OLIVE GRACE POTTER umber or Rural Route Number, City or Town, Stete, Zip Code) INCHESTER, VA. 22601 DATE 20c. LOCATION — City or Town, State | | | | | | |
| 5 | 190. INFORMANT'S NAME (Typo/Print) FREDIA I. TEVALT | The second secon | | | Zip Code) | | | | | |
| | 20a. METNOD OF DISPOSITION 1) Burlel 2 Cremation 3 Removal from State | 20b. PLACE AND DATE OF cemetery, cremetory or other | DISPOSITION (Name of | DATE 20c. LOCATION | | | | | | |
| | 22. NAME AND ADDRESS OF FACILITY 57 BERKELEY PRINCE, WV BOUND AND ADDRESS OF FACILITY 57 BERKELEY PRINCE, WV BOUND AND ADDRESS OF FACILITY 57 BERKELEY PRINCE, WV BOUND ADDRESS OF FACIL | | | | | | | | | |
| CERTIFICATION | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fellure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| MEDICAL | PART II. Other significent conditions contributing | to death but not resulting in | the underlying cause given i | Part I. 24a. WAS AN AUTOP PERFORMED? 1 YES 2 NO | AMAILABLE PRIOR TO | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) | | | | | | | | | |
| YSIC | EXAMINER? HOSPITAL: OTHER: 1 Impetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) | | | | | | | | | |
| D BY | 2 Accident Investigation 28s PI ACE OF IN HIGH AT TOWN from street forders will be a set of the control of the | | | | | | | | | |
| APLETE | 29e. CERTIFIER (Check only) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner se stated. | | | | | | | | | |
| BE COMPL | one) MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and piace, and due to the ceuse(e) end menner es stated. 29b. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | |
| TO | 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 20. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 21. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 22. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 23. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 24. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) | | | | | | | | | |
| | 31. DATE FILED (Marty Day, Year) 1994 32 AFGIST | RAR'S SIGNATURE | | | | | | | | |



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with completely filled in by the funeral director, page 5 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | |
|--------------------|--|--|---|---------------------|---|--|--------------------|---------------------------------|--|--|--|
| - 3 | 1. DECEDENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH MONTH DAY | 3. TIME OF DEATH | | | | | | | | |
| - 77 | William R. Mon | liam R. Monroe | | | | | | 10:05 AH | | | |
| | 4. SOCIAL SECURITY NUMBER 5. S | | rs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH | 1994 8. BIRTI | IPLACE (State or Foreign | | | |
| - 13 | | | 8 YRS. | | | 7/30/36 | Mai | yland | | | |
| or. | 9e. FACILITY NAME (If not institution, give street a | | , | | OR LOCATION OF E | | 9c. COUNTY OF D | EATH | | | |
| DIRECTOR | Union Memoria | I Hospita. | L | Bal | timore | City | na | | | | |
| 3 | 10a. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN OR LOC | ATION | | | 10d. INSIDE CITY LIMITS? | | | |
| 5 | Maryland na | e | 1 TYES | | | | | | | | |
| FUNERAL | 10e. STREET AND NUMBER | of. ZIP CODE | | 10g. CITIZEN OF | and the second second | | | | | | |
| ÿ | 6116 Belair Road | | | | 2 1 2 0 6 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No | | | | | | |
| | 11. MARITAL STATUS 1 Never Married 2 Married 12. WAS DECEDENT EVER IN U.S. ARM FORCES? 1 YES 2 NO | | | It yes, s | or No- 14. RACI Blac | E — American Indian, k, Whita, atc. | | | | | |
| B | 3 🗍 Widowed 4 🗌 Divorced | F YES, GIVE WAR OR DATE | S | 1 🗆 YE | White | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working | | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| | Elementary/Secondary (0-12) Col | lege (1-4 or 5 +) | iffe. Do NOT u | se retired.) | ost or working | Paint | ting | | | | |
| MP | 8 | | | | | | | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) William Monr | 0.0 | | | 18. MOTHER'S N. | AME (First, Middle, Meiden S | iumame) | | | | |
| H | 19a. INFORMANT'S NAME (Type/Print) | 06 | 105 114 11 114 | ADDRESS (Or | | | | | | | |
| 임 | The in other of the (typer inty | | 190. MAILING | ADDRESS (Street | and Number of Hural | Route Number, City or Town | , State, Zip Code) | | | | |
| | 20a. METHOD OF DISPOSITION | 20b. PL | ACE AND DATE | OF DISPOSITION // | lame of | DATE 20c. LOC | ATION City or To | nwn. Stata | | | |
| | 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal f | 20s. METHOD OF DISPOSITION Date Commetted Comme | | | | | | | | | |
| | 21. SIGNAPOTIE OF FUNERAL SERVICE LICENSE | I SUMMOTHE OF TUNERAL SERVICE LICENSER On ald Wade, Dir 22. NAME AND ADDRESS OF FACILITY State Anatomy Board | | | | | | | | | |
| | may /// | 2111 | | 655 | W.Balti | more St,B | alto,MI | 021201 | | | |
| 1 | 23. PART I. Enter the diseeass, or comp | lications that caused th | a death. Do | not antar tha m | oda of dying, au | ch as cardiac or reapir | atory arrast, | Approximate Interval Between | | | |
| Į | ahock, pr heert fellure. List only one ceuse on each line. | | | | | | | | | | |
| | disesse or condition resulting in death) ### HEPATIC ENCEPHALOPATHY DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| | | | | | | | | | | | |
| NO N | Sequentially list conditione, If any, leading to immediate cause. Enter UNDERLYING CAUSE, (Disease or Injury. C. CHRONIC ALCOHOL ARUSE | | | | | | | | | | |
| CERTIFICATION | | | | | | | | | | | |
| Ĕ | that initiated events CAUSE (Disease or Injury Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| | resulting in deeth) LAST | | | | | | | | | | |
| | PART II. Other significent conditions cor | atributing to deeth but | not resulting | in the underlyl | on ceuse alven ir | Part I 24- WAS AN A | urmaney 246 | WERE AUTOPSY FINDINGS | | | |
| CA | PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? | | | | | | | | | | |
| | 1 YES 2 NO OI | | | | | | | | | | |
| Σ. | 1 TES 2 NO | | | | | | | | | | |
| PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | | | |
| Sign | EXAMINER? | SPITAL: Inpetient 2 - ER/Outpetie | int 3 🗆 DOA | OTHER: 4 Nursing Ho | me 5 🗆 Rasidenca | 6 Other (Specify) | | | | | |
| H | 27. MANNER DF DEATH | 28a. DATE DF INJURY (Month, Day, Year) | 28b. TIN | | JURY AT ORK? | 28d. DESCRIBE HOW IN | JURY OCCURED | | | | |
| B | 1 Natural 5 Pending 2 Accident Investigation | | M 1 | YES 2 NO | | | | | | | |
| 유 | 3 Suicide 6 Could not be 4 Homicide datarmined | Ca | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| COMPLETED | | | | | | | | | | | |
| MP | (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| ဗ ူ | One) 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 띪 | 290. SIGNATURE MO TITLE OF CERTIFIER 290. LICENSE NUMBER 290. LICENSE NUMBER 290. DATE SIGNED /M AT 2438946 8/31 | | | | | | | | | | |
| 임 | 30. NAME AND ADDRESS OF PERSON WHO COM | MEAICA L | (ITEM 27) (Type | Print) | 771 243 | 9776 | 5/3 | 1779 | | | |
| | ARVINDER BAINS, DEPT. OF MEDICINE, UNION MEMORIAL HOSP., BALTIMORE, MD | | | | | | | | | | |
| | 21 DATE PRIED (Month Box Mark | | | | | , | | -10 | | | |
| | SEP _ 8 1994 | About | colall | | | | | - 1 | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the most of the found of the most of the most of the most of the most of the most of the most of the most of the most of the attention physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | UE | PERMIT | CALE | : OF | DEA | H | R | EG. NO. | | | |
|--|--|----------------------------------|----------------|-----------|---|-----------|------------|----------------------------------|-----------------------|---|-------------|------------|--|
| , | VIDCINIA MADITINI MONTH DAY YEAR | | | | | | | | 3. TIME OF DEATN | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. | | | hirthday | IF UNDER | 1 VEAD | IF UNDER | 04 1400 | AUGUS 7. DATE OF E | | 19 | 94 | 1:52 P M |
| | 220-28-3570 | 1 🗆 M 2 🏋 F | 52 | YRS. | MONTHS | DAYS | HOURS | 0.0104 | (Month, De | v. Year) | 142 | Count | NPLACE (State or Foreign ry) ISYLVANIA |
| 1 | 9e. FACILITY NAME (If not institution, give : | | | | 9b. CITY, | TOWN C | R LOCATI | ON OF DEA | ATH | | | NTY OF D | |
| DIRECTOR | THE JOHNS HOPKINS HOSPITAL | | | | BAL | TIM | ORE (| CITY | | | | | |
| 5 | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT | v | | 40 - C/T) | TOWN | | 1011 | | | | | | |
| E I | MARYLAND PRINCE GEORGE | | | | BLADENSBURG | | | | | | | LIMITS? | |
| | 10e, STREET AND NUMBER | | | | DL | | . ZIP CODI | | | | 40- 017 | 17511 05 1 | 1 YES 2 NO |
| FUNERAL | 5002 57TH AVENUE, # A-6 | | | | | 20710 | | | | | 11511 | USA | WHAT COUNTRY? |
| 5 | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED | | | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Ye | | | | | | or No- | 14, RACI | E — Americen Indien, k, White, etc. |
| B | 1 Never Merried 2 Married FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES. | | | | If yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 YES 2 NO Specify: | | | | | | | "y: WHITE | |
| 9 | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | | EDENT'S | | | | 202 | 16b. KIN | O OF BUS | INESS/IN | DUSTRY | |
| 9 | Elementery/Secondary (0-12) College (1-4 or 5 +) | | | | | | | | | | } | | |
| COMPLETED | 12 Ø BOO | | | OOKKI | TEEPER CPA 18. MOTNER'S NAME (First, Middle, Meiden Surreme) | | | | | | | | |
| | VIRGIL J. BLOOD | | | | | | | | TH HER | | Sumeme) | | |
| B | 19a. INFORMANT'S NAME (Type/Print) | | 19b | MAILING | ADDRESS | (Street e | | | oute Number, C | | n State Zie | n Code) | |
| 2 | DIANA D. CARLOCK | | | | | | | | | | | , | D 20723 |
| | 20e. METNOD OF DISPOSITION | sound from Chat- | 20b. PLACE A | ND DATE O | FDISPOS | ITION (Na | me of | | DATE | 20c. LO | CATION - | City or To | own, State |
| j | 1 Donetion 5 Other (Specify) | | BALTI | MORE | WAS1 | HING | TON | CREM | 9/1 | LAU | REL, | MAR | YLAND |
| Committed 2 X Cremetton 3 Removal from State Committed Committed Part | | | | | | | | | | | | | |
| | Calal | Dulle | agker | | | 7601 | SAN | DY SI | PRING | ROAD | , LA | UREL | , MD 20707 |
| | 23. PART I. Enter the dieeeses, or ehock, or heart ellure. | complications that c | affeed the fee | th. Do n | ot enter | the mo | de of dyl | lng, such | as cerdiec | or respi | ratory ar | reet, | Approximate |
| | ehock, or heart ellure. List only one cause on each ins. IMMEDIATE CAUSE (Final | | | | | | | | | | | | |
| | disease or condition resulting in deeth) | . Oyperam | morehu | | Da | 6 | en | | | | | | lday |
| _ | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditione, If eny, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| S | cause. Enter UNDERLYING CAUSE CONTRACTOR CON | | | | | | | | | | | | |
| | that initieted events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| E I | resulting in deeth) LAST d. Coulcom a 3 vn culture | | | | | | | | | | | | |
| | PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | | . WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | | |
| EDICAL | CO | | | | | | | COMPLETION OF CAUSE OF DEATH? | | | | | |
| ME | | | | | | | | | _ , ' | | | | 1 YES 2 NO |
| | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO | | | | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) OTHER: | | | | | | | | | | | | |
| IYSI | 1 VES 2 NO | 1 Inpetient 2 🗆 El | | | 4 🗌 Nurs | ing Nom | | | Other (Sp | | | | |
| | 27. MANNER OF DEATH 1 Netural 5 Pending | 28e. DATE OF IN. (Month, Day, | | 28b. TIME | | | RK? | | 28d. DEŞCRII | BE NOW IN | NJURY OC | CURED | |
| BÁ | 2 Accident Investigation Inves | | | | | | | | Route Number, | | | | |
| TEO | Suicide S Could not be determined Suicide S Could not be determined Suicide S Could not be determined | | | | | | | | | | | | |
| 2 | 29e. CERTIFIER (Check only (Check only) (Che | | | | | | | | | | | | |
| COMPLET | one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(e) and menner as stated. | | | | | | | | | | | | |
| BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETE CAUSE | OF DEATH (ITEM | 270/16-0- | Print) | | |) 2 | 000 | | | 0/ | 50 74 |
| | , and the second | contina | of the | plen | 900 | n cet | ogu | - | | | | | |
| 31. DATE FILED (Month, Day, Year) 32. RECESTRAN'S AYGNATURE | | | | | | | | | | | | | |
| | SEP 0 8 1994 A | not an imarious | mana44 | | | | | | | | | | |

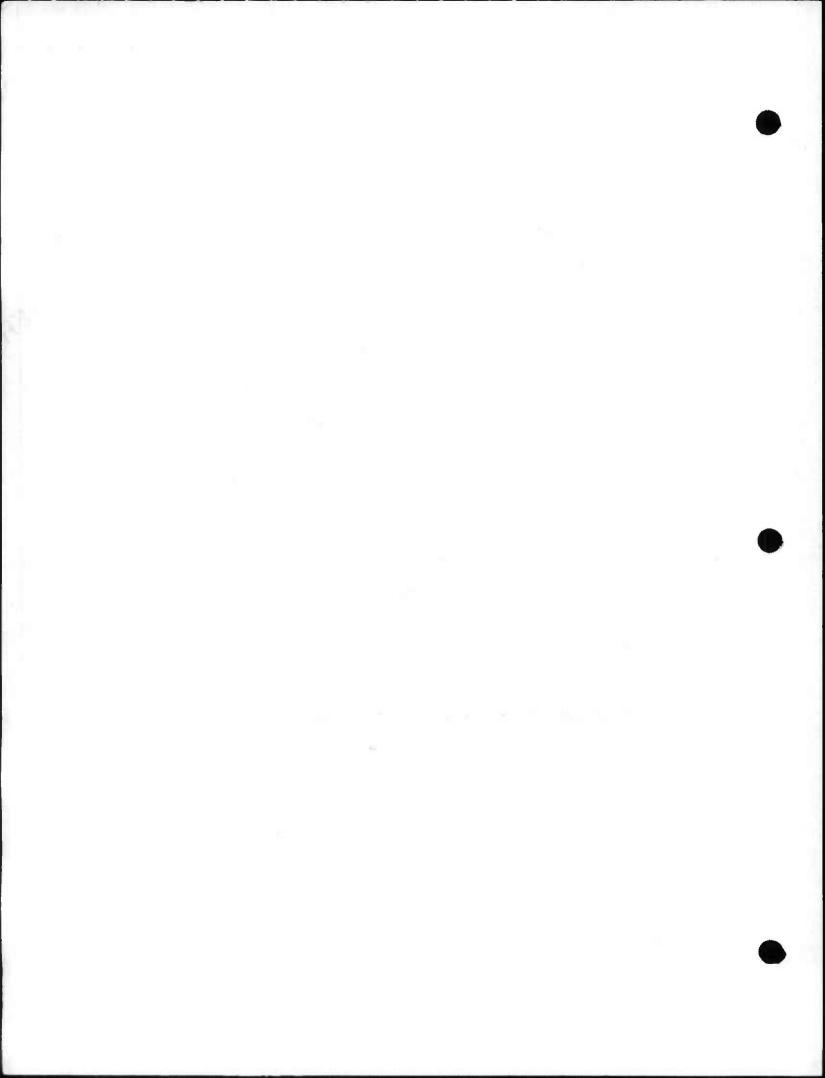
Laster and the same BALTIMORE, MARYLAND 21215-0020

SION OF VITAL RECORDS, P.O. BOX 68760 NDING PAYSICIAN: The law requires that the deuth certificate be executed within

| | within withouts after death. Page 6 may be retained by the hospital or attending physician. | greed by the amendang physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | Central |
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| | | ely filled | nation. |
|) | ed with | omplet | al, cren |
|) | the death certificate be execute | and o | to buri |
|) | cate be | hysicial | Drior |
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| | # death | 報え | Vental |
| | that th | A D | Date of |
| | N. The law requires that | ath has been signed | of Health |
| | Ä | 見 | Dept |
| | | | State |
| | WSIDN | THO S | 新加 |
| | THE BRIDE | R. Ather this certific | or death with the State Dept. of Healt |
| | 高 | ĠĊ. | 2 |

marked, or tem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,

| | 1 - FOR STATE OF MARY | LAND / DEPARTI CERTIFIC | MENT OF HEALTH AND | MENTAL HYGIE | | |
|------------------|--|--------------------------------|--|--|--------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | Raymond B. Nicolaus | | | Sept. 8 | , 1994 | 6:15 A M |
| | | | F UNDER 1 YEAR IF UNDER 24 HR | 7. DATE OF BIRTH | 8. BIR | THPLACE (State or Foreign intry) |
| | 168-05-7866 ¹⊠™2□F 7 | 6 YRS. | ONTHE DAYS HOURS MIN | | | nsylvania |
| | 9a. FACILITY NAME (If not institution, give street and number) | | b. CITY, TOWN OR LOCATION OF | OEATH | 9c. COUNTY OF | |
| 힏 | Meridian Severna Park Nursin | g Home S | everna Park | | Anne A | Arundel |
| EC | 10s. STATE 10b. COUNTY | 10c. CITY, 1 | TOWN OR LOCATION | | | 10d. INSIDE CITY |
| ā | Maryland Anne Arundel | Pa | sadena | | | LIMITS? |
| 3AL | 10e. STREET AND NUMBER | | 101. ZIP CODE | | | WHAT COUNTRY? |
| FUNERAL DIRECTOR | 7652 Berry Drive | | 21122 | | United | States |
| J. | 11. MARITAL STATUS 1 Never Married 2 Married 12. WAS DECEDENT EVER FORCES? 1 YES | 2 NO | 13. WAS DECENDENT OF HIS It yes, specify Cuban, Mer | dcan, Puerto Rican, etc.) | fes or No- 14. RA Ble | CE — American Indian, ack, White, etc. |
| B≺ | 3 Wildowed 4 Divorced IF YES, GIVE WAR OR | DATES | 1 TYES 2 X NO Sp | ecify: | Sp | ∞cMy: White |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 16a. DECEDENT'S US | SUAL OCCUPATION is done during most of working | 16b. KIND OF B | USINESS/INDUSTRY | |
| Ē | Elementary/Secondary (0-12) College (1-4 or 5+) | life. Do NOT use r | etired.) | | | 1 |
| MP | 12 | Computer | Analyst | Westing | | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | NAME (First, Middle, Malde | en Surname) | |
| BE | Jacob Nicolaus 19e. INFORMANT'S NAME (Type/Print) | 105 MAIL DIG AL | Mary B | | | |
| 2 | Nancy S. Thomas | | bleside Dr., | | | od 21146 |
| | 20a, METHOD OF DISPOSITION 20 | b. PLACE AND DATE OF | DISPOSITION (Name of | | OCATION — City or | |
| | | metery, crematory or other | e MD Vet. Cem | 9-12 Cr | ownsville | e, Maryland |
| | 21. SIGNATURE OF FUNETIAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF | FACILITY | | 7 |
| | V Kell all | _ | Kirkley-Rudo 421 Crain Hv | lick Funera | 1 Home | MD 21061 |
| | 23. PART I. Enter the diseases, or complications that cause | ed the death. Do not | enter the mode of dying, a | uch as cardiac or res | piratory arrest, | Approximate |
| | shock, or heart failure. List only one cause on IMMEDIATE CAUSE (Final | each line. | | | | Interval Between Onaet and Death |
| | disease or condition resulting in death) | OLE MYS | comes insty | | | YEARS |
| | DUE TO (OT AS | A CONSCIOUENCE DE): | 7./ | | | |
| NO N | Sequentially list conditions, b. | HIA! | 740 | | | |
| ΙΨΧ | If any, leading to immediate cause. Enter UNDERLYING | reflest | 122 | | | |
| 트 | CAUSE (Disease or Injury that Initiated eventa DUE TO (OR AS | A CONSEQUENCE OF): | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | |
| AL CI | PART II. Other aignificant conditions contributing to death | but not resulting in | the underlying cause given | in Part I. 24a WAS A | AN AUTOPSY 2 | 4b. WERE AUTOPSY FINDINGS |
| S | CHRONGE OBSTRUTTO | 4) | KARY DISEA | PERF | ORMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| Ē | • • | | 1000 | 1 TES | 2X NO | OF DEATH? |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRIBUTE TO | CAUSE OF D | EATH YES N | 0 | | |
| CIAI | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | | 26. PLACE OF DEATH | (Check only one) | | |
| YSI | 1 YES 2 NO 1 Inpatient 2 ER/Ou | | THER: Nursing Home 5 V Beauty | e 6 Other (Specify) | | |
| PH | 27. MANNER OF DEATH 1 Netural 5 Pending 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME C | Y WORK? | 28d. DESCRIBE HOW | INJURY OCCURED | |
| BY | 2 Accident Investigation | | M 1 YES 2 NO | | | |
| TED | 3 Suicide 8 Could not be determined 298. PLACE OF INJUR | tY — At home, term, streecify) | et, factory, office | 26f. LOCATION (Stree City or Town, Star | | il Route Number, |
| | 29a. CERTIFIER | | | | | |
| COMPLE | (Check only one) 2 MEDICAL EXAMINER: On the best of examinet | | | | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | |
| BE | South Size All Miles of Services | 4.0 | 29c. LICENSE | 999/ | | ED (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF D | EATH (ITEM 27) (Type, Pr | int) | (() | I sept | . 0, 1334 |
| | David Rose, M.D., 300 Hospi | | | Maryland 2 | 21061 | |
| 1 | SEP 0 8 1994 June Sensor | | | | | |
| | 3EF U 0 1337 | 1 | | | | |



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| | certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | | |
|--|---|--------|--|
| | 1. 2. | | |
| | Pages | | |
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| 9 | ector, | | - |
| 30 | al din | | 001 |
| SICIAN: The law requires that the death certificate be executed within amounts after death. Page 6 may be retained by the hospital or atte | funer | | I as them 90 about and faither the second the modern than the second the second that |
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| OUIS | in b | or rer | The sale |
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| | | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | RTMENT OF H | | MENTAL HYGIEN | | | |
|--|---------------|---|---|---------------------------------|------------------------------|---------------------------------------|--|----------------------|---|-------|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | N |
| | | Ruth Cecile | e Niles | | | | September (| 5 1994 | | рм |
| | | | | In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTN (Month, Day, Year) | Cou | TNPLACE (State or For | eign |
| Pinc | | 215-32-6697 9a. FACILITY NAME (If not institution, give stree | 1 M 2 X F | 85 YRS. | | | 9/24/19 | | ew York | _ |
| 3 sho | E. | 3701 White Ave | | | | timore | АТН | 9c. COUNTY OF | DEATH | |
| 1, 2, | CTO | RESIDENCE OF DECEDENT | | | | | | | | |
| Pages | DIRECTOR | Maryland 106. COUNTY | | | ry, town on Locat Baltimo | | | | 10d. INSIDE CITY LIMITS? | |
| THE . | | 10e. STREET AND NUMBER | | | | ZIP CODE | | 10- OIT(751) OI | 1 X YES 2 1 | NO |
| physician. burial-transit permit. Pages 1, 2, 3 should | FUNERAL | 3701 White Ave | าแค | | 100 | 21206 | | | d State: | ٠ |
| physician burial-trar | N D | 11. MARITAL STATUS | 2. WAS DECEDENT EVER IN | | 13. WAS DEC | ENDENT OF NISPAN | IC ORIGIN? (Specify Yea | or No- 14. BA | CE — American India | |
| | ВУ Б | 1 Never Married 2 X Married 3 Widowed 4 Divorced | FORCES? 1 YES | | | ecify Cuban, Maxican 2 NO Specify: | | | eck, White, etc. Octiv: White | |
| attending se as the | ED E | 15. DECEDENT'S EDUCA | TION | 16e DECEDENT'S | USUAL OCCUPATION | DN: | 16h KIND OF BUS | SINESS/INDUSTRY | | |
| f or at or use | ᆸ | (Specify only highest grade co | mpleted) College (1-4 or 5 +) | (Give kind of life. Do NOT u | work done during mo | st of working | | | | |
| he hospital or attend detached for use as once. | COMPL | 14 | | Tea | cher | | Baltimore | e City Pub | olic Schools | |
| - | | 17. FATHER'S NAME (First, Middle, Last) Francis Cecil | Pandon | | | | AE (First, Middle, Maiden | | | |
| ned by ould be ied at | BE | 19e. INFORMANT'S NAME (Type/Print) | Paruon | 10b MAII ING | ADDRESS /Street of | | largaret | | | _ |
| 5 should notified | 2 | Mr. Charles H. | Niles | | | e Avenue | | more, M | d. 2120 | 6 |
| A 8 0 | | 20a. METNOD OF DISPOSITION 1 Burlal 2 Cremation 3 Remove | 206 | PLACE AND DATE | OF DISPOSITION (Na | ame of | | CATION — City or | | Ť |
| ge 6 may irector, p | | 4 Donation 5 Other (Specify) | Hi | | rither place) /ice Corpor | | 9/9/94 To | wson, I | Maryland | |
| death. Page 6 may funeral director, pa f. | | 21. SIGNATURE OF FUNERAL SERVICE LICEN | Mark I. | Zavoy | na 22. NAME AN | nandaness of FAC | Ruck, I | | | |
| | | > Mark T. Za | // | | 530 | b Hartoi | rd Road | Baltin | nore,212 | 14 |
| in by rem | | 23. PART I. Enter the diseesea, or con shock, or heart feliure. Lie | mplications that caused at only one cause on e | the deeth. Do | not enter the mo | de of dylng, such | aa cardiec or respi | retory erreat, | Approxima interval Be | |
| no. | | IMMEDIATE CAUSE (Finel disease or condition | (1)6. la | 4 | | 0 | -01- | 7 ^ | Onset and | |
| completely fille completely fille rial, cremation, | | reaulting in death) | DUE TO (OR AS A | CONSEQUENCE | AL - | fivere | - July | 200 TA | me | |
| and com o burial, o | z | 6.0 | 2 (Lefin | - W | an | a Cas | Jeina | 4 | | |
| 8 " 0 = | CERTIFICATION | Sequentielly list conditions, if any, leading to immediate | DUE TO TOR AS A | CONSEQUENCE | 7 | - Com | p . | | | |
| icate t physici ie prio er tra | 2 | CAUSE (Disease or injury | DIJE TO (OR AS A | CONSEQUENCE O | up (| aus | well | elenie | d | |
| leath certificate be a attending physician mal Hygiene prior to y, or other traun | E | that initiated events resulting in death) LAST | DOE TO TON AS A | CONSEQUENCE | r). | | | | | |
| 0 6 | | DARY II Oshan algariticana and itina | | | | | | | | |
| t bud | CAL | PART II. Other significent conditions | contributing to deeth b | ut not resulting | In the underlying | g ceuse given in i | Pert i. 24s. WAS AN PERFOR | | 46. WERE AUTOPSY FIN AWAILABLE PRIOR T | 0 |
| | MEDIC | | | | | | 1 YES 2 | KNO | OF DEATH? | AUSE |
| of of | | DID TOBACCO USE CO | ONTRIBUTE TO | CAUSE OF | DEATH Y | ES I NO | | | 1 YES 2 N | ° |
| ate has be tate Dept. | PHYSICIAN | 25. WAS CASE REFERRED TO MEDICAL | | <u> </u> | | ACE OF DEATH (Che | | | | |
| SICIAN: The las certificate has the State Dep 1, or item 23 | YSIC | 1 TES 2 THO | OSPITAL: Inpetient 2 ER/Outp | stlent 3 🗆 DOA | OTHER: 4 Nursing Nom | e 5 XRaaldence | 5 Other (Specify) | | | |
| NG PHYSIC fter this ce eath with the | PH | 27. MANNER OF DEATH 1 Natural 5 Pending | 28e. DATE OF INJURY (Month, Day, Year) | 28b. T/A | JURY WO | RK? | 28d. DESCRIBE HOW II | NJURY OCCURED | | |
| After 1 death death s mar | ВУ | 2/ Accident Investigation | 28e. PLACE OF INJURY | — At home farm | | rES 2 NO | 281. LOCATION (Street a | and Mumber or Com | I Brooks Morehan | - |
| OR ATTENDING DIRECTOR: After hours after death Item 28 is ma | TED | 6 Could not be datermined | building, stc. (Spec | | | | City or Town, State) | and reamber of right | r node Namber, | |
| DIRECTOR: hours after Item 28 i | PLET | 29a. CERTIFIER 1 CERTIFYING PHYSICIA | IN: To the best of my knowl | edga, dasth occurr | red at the time, data | and place, and dua t | to the cause(e) and man | oper as stated. | | |
| HOSPITAL FUNERAL WITHIN 72 I | OMPL | one) 2 MEDICAL EXAMINER: | | | | | | | e(s) and manner as str | rted. |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law TO THE FUNERAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dept IMPORTANT: If Item 28 is marked, or Item 23 | U U | SIGNATURE AND TITLE OF CERTIFIER | 1 | ` | | 29c. LICENSE NUM | BER | 29d. DATE SIGNI | ED (Months Day, Year) | |
| 50 50 M | 0 8 | Moed W. W | With Mil |), | | \$07. | 246 | 1917 | 144 | |
| | | NAME AND ADDRESS OF PERSON WHO | CALLED CAUSE OF DE | ATH (ITEM 27) (Type | BAZ | TIME | WE MI | , , , | 10 | |
| | | 31. DATE FILED (Month, Dey, Year) | 32 CHECKIST ATTA SHAPE | surelanda. | VIL | -1/ 000 | ice jud | 410 | LF | |
| | , | SEP 0 8 1994 | 0 | TO STATE OF THE STATE OF | | | | | | |

Type of the second

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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITATO TO THE FUNERAL DE filed within 72 m

| | 1 - FOR STATE REGISTRAR | ATE OF MARYLAN | ND / DEPARTI | MENT OF H | EALTH AND I | MENTAL HYGIEN | | 20000 |
|----------------------|---|---|---|---------------------|--|--|------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) May Ellen | Peckew | | | | 2. DATE OF DEATH MONTH DE | | |
| | 4. SOCIAL SECURITY NUMBER 5. SE | 6. AGE (In) | yrs. lest birthday) II MC | F UNDER † YEAR | IF UNDER 24 HRS. HOURS MIN. R LOCATION OF DE | 7. DATE OF BIRTH (Month, Day, Year) April 25, | 8. BH Co | nnsylvania |
| TOR | Carroll County Genera | | | Vestmin | | AIR | Carro | |
| DIRECTOR | 10e. STATE 10b. COUNTY Maryland Carroll | | | TOWN OR LOCAT | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 XNO |
| FUNERAL | 100. STREET AND NUMBER 200 St. Luke Circle | | | | ZIP CODE 2.1.1.5.8 | | - 31 | F WHAT COUNTRY? |
| BY FUNE | 11. MARITAL STATUS 12. W | AS DECEDENT EVER IN U DRCES? 1 TYES YES, GIVE WAR OR DATE | 24 NO | 13. WAS DEC | ENDENT OF HISPAN | IIC ORIGIN? (Specify Yes n, Puarto Rican, etc.) | 8 | ACE — American Indian, lack, White, atc. pecify: |
| COMPLETED | | ed) ge (1-4 or 5 +) | 8a. DECEDENT'S US (Give kind of work life. Do NOT use n | k done durina mos | | 16b. KIND OF BUS | | White |
| OME | 12 Years 17. FATHER'S NAME (First, Middle, Last) | |)wner | - | 18. MOTHER'S NA | Hardwar | | |
| BE (| Unkown Wilson 190. INFORMANT'S NAME (Type/Print) | _ | | | Annie | Unknown | | |
| 유 | Mr. Scott Davis | | | | | Route Number, City or Town Pikesvill | | |
| | 20s. METHOD OF DISPOSITION 1 | | | | ne of | DATE 200 LO | CATION - City or | Town State |
| | 21. SIGNATURE OF PUMERAL SERVICE LICENSEE | | | Loring | Byers | Funeral Di | rectors | |
| CERTIFICATION | Sequantially list conditions, | DUE TO (OR AS A CO | ONSEQUENCE OF): | u f | ailus | e | retory arrest, | Approximate interval Between Oneet and Daeth / day / day |
| PHYSICIAN: MEDICAL C | PART II. Other algorificant conditions control | ributing to death but | not reauting in t | | cause givan in | Part i. 24e. WAS AN PERFOR | MED? | 14b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| AN: | DID TOBACCO USE CONTRIBUT 25. WAS CASE REFERRED TO MEDICAL | | DEATH YES | | UNCERTAIN | 10 | | |
| VSIC | 1 TYES 2 NO 1 IN | PITAL: patient 2 - ER/Outpetie | | THER: | 5 🗆 Rasidenca | 6 Other (Specify) | | |
| ВУ РН | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 8a. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | Y WOI | RY AT IK? ES 2 NO | 28d. DESCRIBE HOW IF | JURY OCCURED | |
| | - Accident | building, atc. (Specify) | At home, term, street | et, factory, office | | 26f. LOCATION (Street a City or Town, State) | nd Number or Run | al Route Number, |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To MEDICAL EXAMINER: On the | | | | | | | e(a) and manner as stated. |
| TO BE C | 296 SIGNATURE AND TITLE OF CERTIFIER | -mD | | | 29c. LICENSE NUN D 446 | BER 14 | 29d. DATE SIGN | ED (Month, Day, Year) |
| | JOHN A STEE | RS MD | 547 | | shingto | n Rd S | ste lo | 2 Westmins |
| | SEP 0 8 1994 | AEGISTIAR'S SIGNATU | Karlally | | J | | | |

The state of the s

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

iours after death. Page 6 may be retained by the hospital or attending physician. the death certificate be executed that OR ATTENDING PHYSICIAN: The law

29b. SIGNATURE AND TITLE OF CERTIFIER

en

907P

31. DATE FILED (Month, Day

91

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

08199

mcci

32. REGISTINAN'S SIGNATURE

BE

2

Pages 1, 2, 3 should permit. been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit at. of Health and Mental Hygiene prior to burial, cremation, or removal. once. notified at ě must examiner the medical event, traumatic or other shows any Dept. 23 certificate h 6 this c marked, After DIRECTOR: An hours after desitem 28 is n TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTO DE filed within 72 hours at IMPORTANT: If Nem 21

94 26364 Item # 16a, 19a, 19b Film # G 715 09-08-94 N.A. Per funeral Home 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 4. SOCIAL SECUR 6. AGE (In yrs. last birthday) F UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Fo IF UNDER 24 HRS. 1 M 2 FF YRS WN OR LOCATION OF DEATH DIRECTOR 0 RESIDENCE EDENT 10e. STATE 10b. COUNTY 10d. INSIDE CITY mox VES 2 NO FUNERAL 10e. STREET 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? d 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-11 MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried e, specify Cube Specify: В 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION ecify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) None. None Student 17. FATHERYS NAME (First, Middle, Last) 18. MOTHER'S NAME (First. BE (190. INFORMANT'S NAME (Type/Print) Mrs. 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or 3414 Edmondson Ave. Baltimore, Page Eva 2 2 Cremation 3 NATURE OF FUNERAL SERVICE LICENSES Enter the diseases, or complications that caused the de-shock, or heart failure. List only one cause on each line. ses, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory erreat, Approximate interval Between IMMEDIATE CAUSE (Finei **Onset and Death** disease or condition tungal 2 whs resulting in deeth) DUE TO (ON AS A CONSEQUENCE OF) Immone CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate MULTO (O IN DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST 16×13 PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 TYES 2 TNO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL ☐ Inpatient 2 ► ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28b. TIME OF 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 5 Pending 1 YES BY 2 NO Acciden Investigation 3 Suicide 26e. PLACE OF INJURY — At home, Jerm, atreet, Jectory, office building, etc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 29a CERTIFIER best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and menner se stated tion end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) and manner ee stated

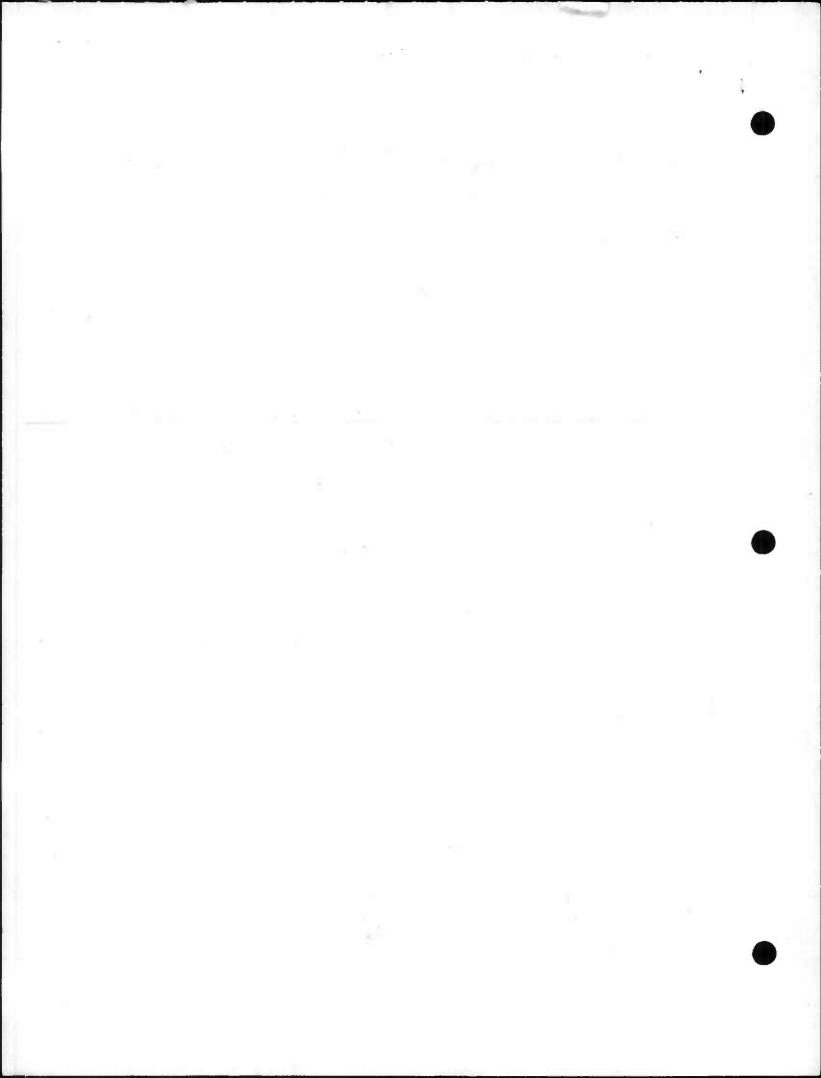
29c. LICENSE NUMBER

5

028

19

29d. DATE SIGNED (Month, Day, Year)



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760.

permit. Pages 1, 2, 3 should use as the burial-transit ours after death. Page 6 may be retained by the hospital or attending physician. funeral director, page 5 should be detached for To notified 9 must medical examiner completely filled in by the rial, cremation, or removal. # event, death certificate be executed with signed by the attending physician and con Health and Mental Hygiene prior to burial, traumatic other 10 Injury. OR ATTENDING PHYSICIAN: The law requires that the amy shows a peen has be Dept. c Item 23 certificate h 6 this c marked. After I death 66 DIRECTOR: / 28 Hem FUNERAL (
within 72 h HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: 1

2

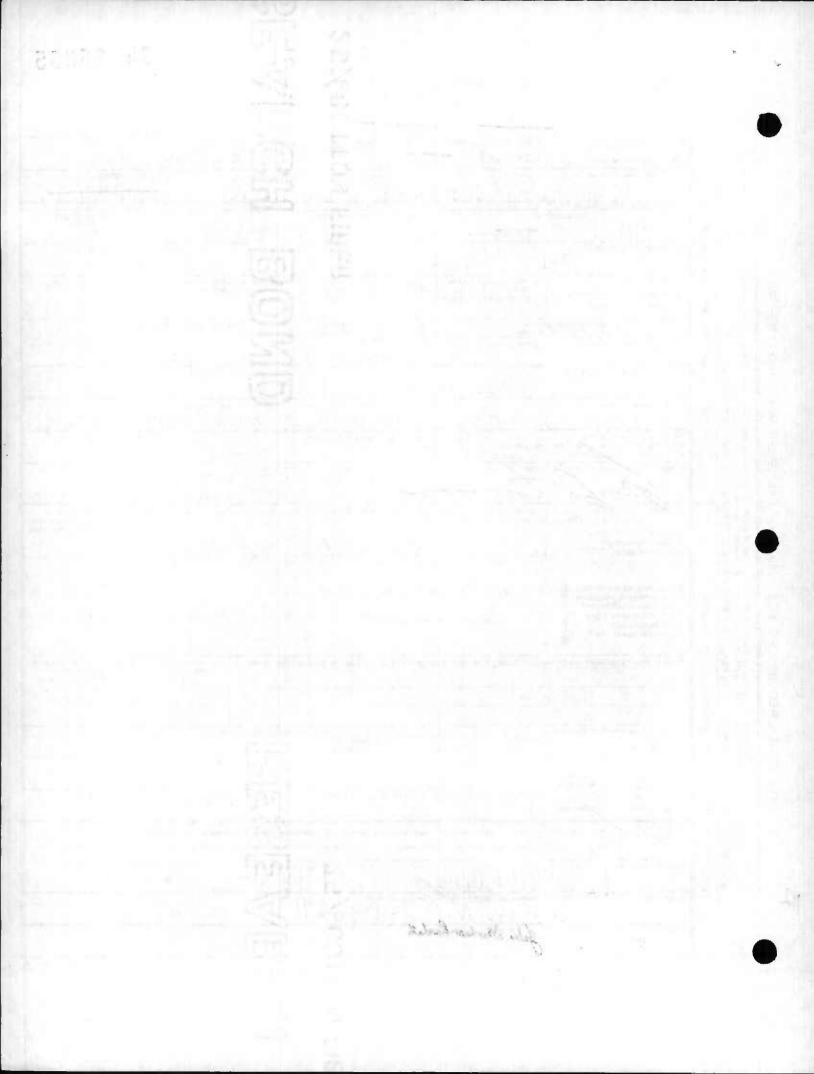
31. DATE FILED (Month, Dev.

139 8 0

Item1, Film715, 9/8/94, 1t FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH 1170 PM 09 7. DATE OF BIRTH (Month, Day, Year 5 - 17-4 SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTNPLACE (State or Foreign 8-MARYLAND 1 M 2 M Sa. FACILITY NAME (If not ins 9c. COUNTY OF DEATH DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION Baltimore 1 YES 2 NO STONE HENGE (FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No. If yes, specify Cuben, Maxican, Puerto Rican, etc.)
 YES 2 MO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 1 Never Married 2 Married BY 3 Widowed 4 Divorced white COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high ntary/Seco ndary (0-12) 12 housewife at home once. 17. FATNER'S NAME (First, Middle, Last. 18. MOTNER'S NAME (First, Middle, Maiden Surname) CHARLES GREENFELD SYLVIA SPECTOR BE 19a. INFORMANT'S NAME (Type/Print) 19b, MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MR. LEONARD PEARLMAN 29 STONEHENGE CIRCLE, APT. 2 BALTIMORE, MD 21208 20a. METNOD OF DISPOSITION
1 Surial 2 Cremation 3
4 Denation 6 Other (Specify) b. PLACEAND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State HAR STNAT Place) 9-4-94 DWINGS MILLS, MD 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215 23. PART I. Enter the di fications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate shock, or hear fallure List only one ceuse on each line interval Between Onset and Daath IMMEDIATE CAUSE (Final disease or condition resulting in death) CERTIFICATION Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 YES 2 NO OF DEATH? 1 YES 2 NO PHYSICIAN: 25. WAS CASE BEFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSFITAL: OTHER 1 ES 2 NO 1 Dinpetient 2 ER/Outpetient 3 DOA me 5 - Residence 6 - Other (Specify) 27. MANNEB-OF DEATH 28a. DATE OF INJURY 26b. TIME OF 28c. INJURY AT WORK? 28d. OEŞCRIBE HOW INJURY OCCUREO 1 Netural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY -- At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be COMPLETED 4 Nomicide 29a CERTIFIER CERTIFYING PHYSICIANS To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, 2 MEDICAL Investigation, in my opinion, death occured at the time, date and piece, and due to the cause(s) and menner as stated. 296. SIGNATURE AND TITLE OF CERT 29d. DATE SIGNEO (Montil, Day, Year) BE 627 a

CAUSE OF DEATH OFEM 27, Typo, PHOD

DHMH-16 Rev 1/89



MARYLAND

10g. CITIZEN OF WHAT COUNTRY?

Specify:

USA

14. RACE — American Indian, Black, White, etc.

994

9c. COUNTY OF DEATH

3. TIME OF OEATH

10d. INSIDE CITY

1 X YES 2 NO

WHITE

Approximate Intarval Between **Onset and Death**

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE

OF DEATH? 1 YES 2 1.HO

29d. DATE SIGNED (Month, Day, Year)

448

GilO A.m.

REG. NO.

3

2. DATE OF CEATH

9

permit. Pages 1, 2, 3 should

use as the burial-transit

10

detached

2

REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

ROSEN

BE

| urs after death. Page 6 m | in by the funeral director, p | redical examiner must |
|---|--|--|
| nted with | completely filled | in or enter traumatic event, the medical ex |
| rimcal he execu | per loss and | mer traumatic |
| I De Gardh of | Section of the | lujur. |
| 8 | | . 5 |
| sainba: v | Seer signed | shows at |
| SICIAN: The law requires | certificate has been signed | or Item 23 shows as |
| ENDING PHYSICIAN: The law requires | DR: After this certificate has "seen unmen | is marked, or item 23 shows as |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law sequents me the executed with fours after death. Page 6 may | TO THE FUNERAL DIRECTOR. After this certificate has "seen upmed by the property produced in by the funeral director, p | be lied within 12 hours after beam with the State Dept. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury or finer trumatic event, the medical examiner must |

(MorAUS Near)30 , 1906 Country) 4. SOCIAL SECURITY NUMBER 218-32-0120 () 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 0129 88 HOURS 1 🗌 M 2 🔯 F YRS. 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH LEVINDALE BALTIMORE DIRECTOR RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION BALTIMORE MARYLAND FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 21209 2813-D DAMASCUS CT. 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-Never Merried 2 Merried If yes, specify Cuben, Mexicon, Puerto Ricen, etc.) 1 YES 2 XNO BY Specify: 3XXWIdowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementery/Secondary (0-12) College (1-4 or 5+) HOUSEWIFE AT HOME once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) DANZIGER BLUMA 70 BE notified 19e. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number of Pural Route Number, City or Town, State, Zip Code)
4001 OLD COURT RD, APT. 420 BALTIMORE, MD 21208 2 MR. LEONARD ROSEN pe 20e. METHDO OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Buriel 2 Cremation 3 Donation 5 Other (Specify) must ARLINGTON-CHIZUK AMUNO 9-4-94 BALTIMORE, MD 4 Donation 23 shows any Injury, or ether traumatic event, the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSI 22 SOL LEVINSON W BROS, INC. 6010 REISTERSTOWN RD BALTIMORE, MD 21215 23 PARVI Enter the diseeeea, of complications that caused the anock, or heart falture. List pnly pna causa pn each line. or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, disease or condition ARDIORESPIRATURY ARESST reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): ONGESTIVE CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING ne TUS clerotic CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 TYES 2 T NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL Hem 28. PLACE OF DEATH (Check only one) HOSPITAL: **EXAMINER?** OTHER 1 ☐ YES 2 ☐ NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation BY 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, ferm, atreet, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number City or Town, State) 8 Could not be COMPLETED 4 Homicide 29e. CERTIFIER
(Chack nnh. 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end menner as stated. 2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) and menner as attack. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

AN!

37 REGISTRAR S CONTUNE

I tem 4, Film 715, 9/8/94, 1t
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

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| nours after death. Page 6 may be retained by the hospital or attending physician. | sician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | | ed at once. |
|---|---|---|---|
| the executed within fours after death. Page 6 may be retained | ician and completely filled in by the funeral director, page 5 shou | rior to burial, cremation, or removal. | id, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| YSICIAN; The law requires that the death certificate | tificate has been signed by the attending phy- | ie State Dept. of Health and Mental Hygiene p | id, or item 23 shows any injury, or other tr |
| TO THE HOSPITAL OR ALLENDING PHYS | TO THE FUNERAL DIRECTOR; After this cer | be filed within 72 hours after death with th | IMPORTANT: If item 28 is marked, |

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1 - STATE REGISTRAR | | CERTIF | CATE OF | DEATH | | REG. NO. | | |
|---------------|--|---------------------------------------|---|-----------------------|------------------------------------|-----------------|-----------------|------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF | OEATH | MEAN | 3. TIME OF DEATH |
| | KATHERINE ELIZABETH RAI | PPOLD | | | | MONTH /3 | 3/94 DAY | YEAR | 10:25 A M |
| | | | yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF | BIRTH | 8. BIR | THPLACE (State or Foreign |
| | | M 2 X F 7 | 4 YRS. | MONTHS DAYS | HOURS MIN. | 12/15/ | 19 | PHĨ | LADELPHIA, PA. |
| _ | 9a. FACILITY NAME (If not institution, give street a | and number) | | 9b. CITY, TOWN | OR LOCATION OF D | EATH | 9 | c. COUNTY OF | DEATH |
| စ္ခြဲ | IVY HALL NURSING HOME | | | | | | | BALTIM | ORE |
| DIRECTOR | 10e. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN OR LOCA | TION | | | | 10d. INSIDE CITY |
| 8 | MARYLAND BALTII | MORE | | | | | | | LIMITS? |
| | 10e. STREET AND NUMBER | | | 10 | f, ZIP CODE | | 10 | Og. CITIZEN OF | WHAT COUNTRY? |
| FUNERAL | 200 McCORMICK AVENUE | | | | 21206 | | | USA | |
| 5 | 11. MARITAL STATUS 12. | WAS DECEDENT EVER IN FORCES? 1 YES | U.S. ARMED | | ENDENT OF HISPAI | | | No- 14. RA | CE — American Indian, ack, White, atc. |
| BY F | 1 Never Married 2 Narried 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DA | TES | 1 Tyes, sp | ecify Cuban, Maxica 2 NO Specif | | n, atc.) | Sp | ecify: |
| | 15. DECEDENT'S EDUCATIO | SM I | | | | | | | HITE |
| | (Specify only highest grade comp | oleted) | 16a. DECEDENT'S (Give kind of v life. Do NOT us | vork done during me | ost of working | | F-EMPL | ESS/INDUSTRY | , |
| <u> </u> | College (1-4 or 5+) 12 College (1-4 or 5+) OFFICE M | | | | | | | N & GARD | EN |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | 01120271 | 10001 | 18. MOTHER'S NA | | | | | |
| BE C | | | | | KATHLYN | HEFLIN | | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street a | and Number or Rural | Aoute Number, (| City or Town, S | itate, Zip Code) | |
| F | RUSSELL W. RAPPOLD, SR | 4 | 200 McC | ORMICK AV | E. BALTIM | ORE, MD. | 21206 | | |
| | 20a METHOD OF DISPOSITION 1 (3 Burlat 2 Cremation 3 Removal t | from State come | PLACE AND DATE O | | | DATE | | ION — City or | |
| | 4 Donation 5 Other (Specify) | G | ARDENS OF | | | /7/94 | BALTIN | MORE, MO | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSE | EE | | | AHN FUNERA | | | | |
| | Chassan Fr | aral bas | m | 7/101 | RELATE ED | RAI TTN | MORE ME | 21236 | |
| | 23. PART I. Enter the diseasea, or comp shock, or heert feilure. List | olicationa that csused | the death. Do n | ot enter the mo | de of dying, suc | h sa cardiac | or reapirate | ory arrest, | Approximets |
| | IMMEDIATE CAUSE (Final | 4 20 20 | | | \ | | | | intervel Between Onset and Daath |
| | disease or condition resulting in death) | Hezh | leme | ris 9 | Desas | 2 | | | |
| | | DUE TO (OR ME A | |): | | | | | |
| S S | Sequentisity list conditions, b. | 000 | leedu | 4 | | | | | |
| AT | if sny, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | CONSECUENCE OF | | | | | | |
| CERTIFICATION | CAUSE (Diseese or Injury that initiated events | DUE TO (OR AS A | CONSEQUENCE OF | 7: | | | | | |
| E | resulting in deeth) LAST | | | | | | | | - 1 |
| 2 | PART II Other circulturat on distance | | | | | | | | |
| DICAL | PART II. Other aignificent conditions con | ntributing to deeth bu | t not resulting i | n the underlyin | g ceuse given in | Part I. 24s | PERFORME | | No. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| Ē | | | | | | 1[| YES 2 | NO | OF DEATH? |
| Σ | DID TOP LOCAL HOLL COLUMNIA | | | | | | | | 1 TES 2 NO |
| AN | DID TOBACCO USE CONTRIBU | | 6. PLACE OF DEAT | | UNCERTAIL | <u> И Ц </u> | | | |
| PHYSICIAN | EXAMINER? HO | SPITAL: | | OTHER: | | | | | |
| Ě | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIMI | | e 5 🗆 Residence | | | RY OCCURED | |
| | 1 Netural 5 Pending | (Month, Day, Year) | INJ | URY WO | RK? | DEGO. | JE (1011 11100 | W COCONED | |
| ВУ | 2 Accident Investigation 3 Suicide a Could not be | 28a. PLACE OF INJURY | - At home, ferm, a | treet, factory, offic | • | 28f. LOCATIO | N (Street and I | Number or Rura | I Route Number, |
| Ē | 4 Homicide datarmined | building, etc. (Specif | у) | | | City or To | wn, State) | | |
| COMPLETED | 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: | To the best of my knowle | dge, death occurre | d at the time, date | and place and due | to the cause(s |) and manner | as stated | |
| 3 | one) 2 MEDICAL EXAMINER: On | | | | | | | | (a) and menner as stated. |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | , | 1 | | 29c. LICENSE NUI | | | | ED (Month, Day, Year) |
| H | And Usella | e MI | | | 726- | 16 | | 91 | 6/04 |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COL | MPLETED CAUSE OF DEA | ГН (ITEM 27) (Type, | Print) | | 1.0 | | 1/(| 717 |
| | DR. UBEROI 4419 | FALLS RD. | | | | | | (889-00 | 076) |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNA | | | | | | | |
| | SEP 0 8 1994 July | Denien Rud | all. | | | | | | |
| | 11 | , | | | | | | _ | DHMH-16 Rev 1/89 |

30. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Julia d'AUGUSTRANS SIGNATURE

CHRISTINE DELIMA, M.D.

SEP 0 8 1994

| DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020 | 020 |
|---|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with rouns after death. Page 6 may be retained by the hospital or attending physician. | physician. |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 sho be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | burlal-transit permit. Pages 1, 2, 3 sho |
| IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |

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94 26368 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH SEPTEMBER 1, PAUL BERNARD RIDDLEMOSER 1994 12:40 Am 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DAYS HOURS MAY 10, Your) 1917 577-03-6523 MARYLAND 1 XM 2 - F 77 Se. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 8234 HARVEST BEND ROAD LAUREL PRINCE GEORGE RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY FLORIDA SARASOTA SARASOTA 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 2016 NO. ALLENDALE AVENUE 34234 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuberi, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, atc. 1 Never Merried 2 Merried
3 Widowed 4 Divorced FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES В Specify: WHITE COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) RETIRED 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Melden Surname) HOWARD RIDDLEMOSER EMMA KELLER BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 DIANE RIDDLEMOSER 14208 OAKPOINTE DRIVE, LAUREL, MARYLAND 20707 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State TSDE Buriel 2 Cremation 3 X Removal from State
Donation 5 Other (Specify) emelery, cremelory or other plecel SARASOTA MEMORIAL GARDENS 9/6 SARASOTA, FLORIDA 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MD 20707 23. PART i. Enter the diseases, or complications that cellsed the death. Do not enter the mode of dying, such as cerdiec or respiratory strest, ahock, Dr heart failure. Liet only one cause on each line. Interval Between **Onset and Death** IMMEDIATE CAUSE (Final Ē disease or condition . CEREBRAL, LUNG & BONE METASIS METASTASIS reaulting in death) 2yrs DUE TO (OR AS A CONSEQUENCE OF) ▶ PROSTATE CARCINOMA CERTIFICATION 3yrs Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated evente resulting in death) LAST PART ii. Other significant conditions contributing to deeth but not recuiting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE DIABETES MELLITUS, BILATERAL CAROTID any 1 TYES 2X 100 OF DEATH? ARTERY STENOSIS 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OTHER:
4 | Nursing Home | 5 | Residence | 8 | Other (Specify) HOSPITAL 1 TES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 27. MANNER OF DEATH 28e. OATE OF INJURY (Month, Day, Year) 28c, INJURY AT WORK? 28d. OEȘCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town. Stete) a Could not be COMPLETED 4 Homicide 29e. CERTIFIER
1 IX CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner ee stated. 2 MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(s) end menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

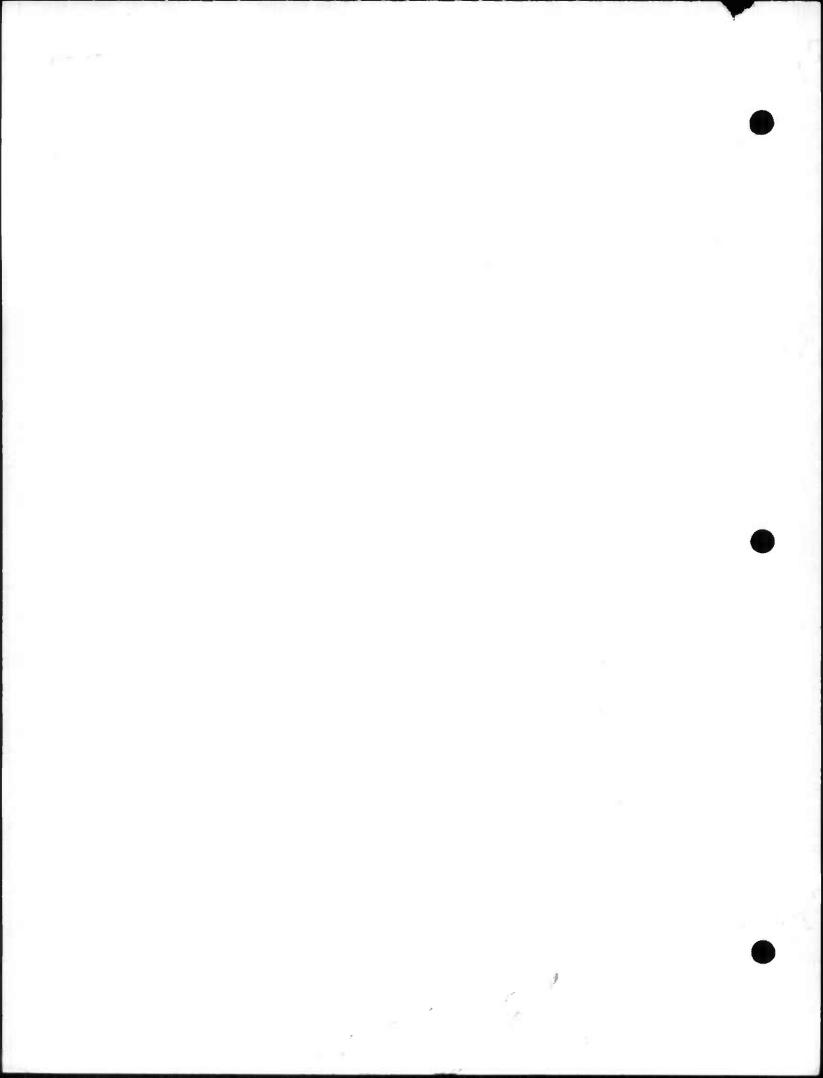
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| BALTIMORE, MARYLAND 21215-0020 | fler death. Page 6 may be retained by the hospital or attending physician. | attending physician and completely med in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be attached for use as the burial-transit permit. | al examiner must be notified at once. | TO BE COMPLETED BY FUNERAL DIRECTOR |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The second for attending physician. Ours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certifical memory of the attending physician and completely med in by the f be filed within 72 hours after death with the Star Drews of the control Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION |

| MEDICAL | San San San San San San San San San San | The state of the s | energy in the underlying course gr | PERFO | PRMED? AL | ERE AUTOPSY FIN MILABLE PRIOR T OMPLETION OF CA F DEATH? |
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| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | OUE TO (OR AS A CONSEQUE ACQUIRED DUE TO (OR AS A CONSEQUE CONTRIBUTION TO closely but not see | ENCE OF): | Deficiency | | |
| | 23. PART I. Enter the diseasea, or conshock, or heart failure. Lie IMMEDIATE CAUSE (Final disease or condition resulting in death) | ot only one cause on each line. | MA LEADING | TO ARIA | | Approxima interval Be Onset and |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | est | Bets | Fynera/ | 12/2/3 Hera 1/2 | 3 All Ca |
| | 26s. METHOD OF DISPOSITION 1 Deurisi 2 Cremetion 3 Remove 4 Donation 5 Other (Specify) | of from State cemeters crema | D DATE OF DISPOSITION (Name of story or other place) | 20c. L | DCATION — City or Town, | , Stata |
| TO BE | 19s. INFORMANT'S NAME (Type/Print) | Anders 196. A | MAILING AODRESS (Street and Number of | or Rurel Route Number, City or Tox | wn, State, Zip Code) | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | Cha lane | 18. MOTH | ER'S NAME (First, Middle, Meider | Sumame) | |
| LETED | 15. DECEDENT'S EDUCAT (Specify only bighast grade co | mpleted) (Give | DENT'S USUAL OCCUPATION kind of work done during most of working o NOT use retired.) | 16b. KIND OF BU | SINESS/INDUSTRY | |
| BY FUN | 11. MARITAL STATUS Never Married 2 Married 3 Wildowed 4 Divorced | 2. WAS DECEDENT EVER IN U.S. ARME FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | If yes, specify Cuban | HISPANIC ORIGIN? (Specify Ye, Mexican, Puerto Rican, etc.) Specify: | se or No— 14. RACE—Black, W Sgeothy | American India: |
| IERAL | 100. STREET AND NUMBER 1634 ARSULE | 11 5+ | 101, ZIP CODE | 218 | 10g. CITIZEN OF WHA | T COUNTRY? |
| DIR | 10a. STATE 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION | | 10 | d. INSIDE CITY LIMITS? |
| ECTOR | FRANCIS SUTT | - Key med cen | | | SE 00011 01 DEXI | |
| | 2/3-80-4484 1 | XM20 = 34 | YRS. MONTHS DAYS HOURS 9b. CITY, TOWN OR LOCATION | MIN. (Month, Day, Year) | Country) | 4 |
| | CI. HORD | SAMDERS i. SEX 8. AGE (In yrs. last bi | irthday) F UNDER 1 YEAR F UNDER 2 | MONTH 9 | 72 54 | 1/34 ACE (State or Fe |

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|--|---|--------|--------|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE MOSPINE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within | pleteh | сгета | IMPORTANT Them 25's marked, or item 23 shows any injury, or other traumatic event, the |
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DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | TIEGIOTIVIT | | | | -11111 | TOATT | | DEA | | | HEG. NO. | | | |
|---------------|---|---------------------------------|------------------------------|--|---|--------------|-------------|-----------------|-----------------|----------------------------|-------------------------------|---------------|---------------------|---|
| | 1. DECEDENT'S NAME (First) | , Middle, Last) FLORE | NCE SIE | EGEL | | | | | | 2. DATE O | F DEATH | 5 1 | 994 | 3. TIME OF DEATH 1430 M |
| | 4. SOCIAL SECURITY NUMBER 108-20-1179 | | 5. SEX 1 M 2 X F | 8. AGE (In yrs. last birthday) F UNDER t YEA 7 2 YRS. MONTHS DAY | | | DAYS | IF UNDER | 24 HRS. MIN. | | Day, Year) | 922 | Countr | |
| | 9a. FACILITY NAME (If not in | | treet end number) | | | 9b. CITY | r. TOWN (| OR LOCATI | ON OF DE | | 11 1 | | TY OF D | W YORK |
| DIRECTOR | GREATER BAI | | E MEDICA | L CENTER | } | | | WSON | | | | 1 | | IMORE |
| <u>ا</u> | 10e. STATE | 10c, CIT | Y, TOWN (| OR LOCAT | TION | | - | | _ | | 10d, INSIDE CITY | | | |
| | MARYLAND | | | | BALTIMORE | | | | | | | | LIMITS? 1X YES 2 NO | |
| ¥. | 10e. STREET AND NUMBER | | | | | | 101 | . ZIP CODI | E | | | 10g. CITIZ | ZEN OF W | HAT COUNTRY? |
| 9 | | ANTERB | URY ROAD | 21218 | | | | | USA | | | | | |
| FUNERAL | 11. MARITAL STATUS 1 Never Merried 2 | Mandad | 12. WAS DECEDEN FORCES? 1 | T EVER IN U.S. AR | MED | 13. | WAS DEC | ENDENT C | OF HISPAN | IC ORIGIN? | (Specify Yee | or No- | 14. RACE Black | - American Indian, White, etc. |
| B | 3 X Widowed 4 Divo | | IF YES, GIVE Y | WAR OR DATES | | | | 2 📉 NO | | | | | | v: WHITE |
| COMPLETED | | EDENT'S EDUC y highest grade | | 16a. DE | CEDENT'S | USUAL O | CCUPATIO | ON | | 16b. I | CIND OF BUS | SINESS/IND | USTRY | |
| <u> </u> | Elementary/Secondery (0 | | College (1-4 or 5 | Itho | ive kind of a Do NOT us | se retired.) | auring mo | St of Workin | ng | | | | | |
| 4 | | | 4 YR | S | SALESPERSON | | | GARTENHAUS FURS | | | | S | | |
| Ö | 17. FATHER'S NAME (First, M | liddle, Last) | | | | | | 16. MOTI | HER'S NA | ME (First, Mi | ddle, Maiden | Surneme) | | |
| BE (| BERNAR | D CHES | S | | EVA DI | | | | DIAMO | OND | | | | |
| 10 | 19e. INFORMANT'S NAME (7 | ype/Print) | | 19 | b. MAILING | ADDRES | S (Street e | and Number | or Rural F | Route Numbe | r, City or Town | n, State, Zip | Code) | |
| F | ERIC SIEGE | | | | | | | | ET, | | | | | D 21211 |
| | fy Buriel 2 ☐ Cremetic 4 ☐ Donetion 5 ☐ Other | n 31 Rem | oval from Stata | camatery, cre KING | 20b. PLACE AND DATE OF DISPOSITION (Name of camatery, crematory or other place) KING DAVID MEMORIAL GDNS. | | | | | /94 PALLS CHURCH, VIRGINIA | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | | | | |
| - 4 | · a. 1 | llar | n Se | ite | 1 | 1 3 | 818 | ROT.A | ND A | VENUE | RAT | TTMO | RE. | 21211 MARYLAND |
| | 23. PART I. Enter the di | iseeses, or c | complications the | t caused the da | eth. Do r | not anier | the mo | da of dy | ing, suct | n as cardi | c or respi | ratory srr | est, | Approximate |
| | IMMEDIATE CAUSE (Final Onset and Death | | | | | | | | | | | | | intarval Batween Onset and Daath |
| | disease or condition resulting in death) s. Acute respiratory failure DUE TO (OR AS A CONSEQUENCE OF) | | | | | | | | | | | days | | |
| | | | | | | | | | | | | | | |
| NO | Sequentially list conditions, DUE TO (OR AS A CONSCOUENCE OF): | | | | | | | | | | | years | | |
| TA. | if any, leading to imme- cause. Enter UNDERLY | NG | Col | | Since of f. | | | | | | | | | 1 |
| E | CAUSE (Disease or inju thet initiated events | IN , | | | INSEQUENCE OF): | | | | | | | | grans | |
| CERTIFICATION | resulting in death) LAS | T . | . Hole | gionella | pne | umb | nicyt | Polio | _ | | | | | yen |
| | PART il. Other significa | int condition | a contributing to | death but not i | reaulting | In the ur | nderlyin | g cause (| given in i | Part i. | 24a. WAS AN | AUTOPSY | 24b. | WERE AUTOPSY FINDINGS |
| EDICAL | malnut | | | | | | | | | | PERFOR | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | 1 | | | | | | | - 1 | 1 YES 2 | M NO | | OF DEATH? |
| ≥ : | DID TOBACCO | O USE (| CONTRIBUT | E TO CAU | SE OF | DEA | TH Y | ES IX | I NO | | | | | 1 TYES 2 NO |
| Ž | 25. WAS CASE REFERRED TO | | | | | | | | | ack only one | | | | |
| PHYSICIAN: | EXAMINER? | ĺ | HOSPITAL: | ER/Outpatient 3 | □ DOA | OTHEI | | 10 5 🗆 Re | esidenca | 6 Other | (Specify) | | | |
| ξI | 27. MANNER OF DEATH | | 28e. DATE Of (Month, L | INJURY | 28b. TIM | | 28c. INJ | URY AT | | _ | RIBE HOW II | NJURY OCC | URED | |
| BY | | Pending Investigation | (********** | , | | M | | YES 2 | □ NO | | | | | |
| | 3 Suicide 6 | Could not be | 28e. PLACE (| OF INJURY — At he etc. (Specify) | me, ferm, | street, fec | tory, offic | | | 261, LOCAT | TON (Street a Town, State) | ind Number | or Rural F | loute Number, |
| ETED | 4 Homicide | detarmined | | | | | | | | Ony Di | iown, state) | | | |
| COMPLET | | | CIAN: To the best of | | | | | | | | | | | |
| 9 | one) 2 MED | ICAL EXAMINE | R: On the besie of e | xemination end/or | Investigation | on, in my o | opinion, d | leath occur | red at the | time, date e | nd place, en | d due to the | e ceuse(e |) end menner as stated. |
| ш | 29b. SIGNATURE AND TITLE | OF CERTIFIE | | | | | | 29c. LICI | ENSE NUM | IBER | | 29d. DATE | SIGNED | (Month, Day, Year) |
| m | Swilling | m /5 | sendich | mi | | | | Do | 85 | 83 | |) (| 117 | 194 |
| 임 | 30. NAME AND ADDRESS OF | | | SE OF DEATH (ITE | М 27) (Туре | , Print) | | | | 4 | | | | |
| | | M BENE | EDICT. C | BMC, TO | WSON. | MAI | RYLA | ND 2 | 1204 | | | | | |
| | 31. DATE FILED (Month, Day, | | 33 REGISTION | R'S SIGNATUR | dalle | | | | | | | | | |
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| 2 | 0 | 90 | IMPORTANT: If them to the month, or them 23 shows any injury, or other traumatic event, the medical examiner must |
| 1 | h-m | - | - |
| | TO THE HOSPITAL OR TELIDING PH SCOAM: The Immunities that the death certificate be executed within 2% hours after death. Page 6 may | TO THE HOSPITAL DR. TELIDING PRESIDENT THE IMPRINGES that the death certificate be executed within 24 hours after death. Page 6 may TO THE FLINEFALL DRESTOR FOR THE FLINEFALL DRESTOR. IN the funeral director, p | TO THE HOSPITAL OR TENDING IN SIGNATING IN IN WHITE THE CHARLE DE EXECUTED WITHIN 24 hours after death. Page 6 may TO THE FUNESAL DEPOTION And THE COMPETED REPORT OF THE FUNESAL DEPOTION AND THE FUNESAL DEPOTION AND THE COMPETED FOR THE COMPETED WITH THE SHARL DEPOTION OF THE COMPETED FOR THE SHARL DEPOTION OF THE SHARL DEPOTION OF THE SHARL DEPOTION OF THE SHARL DEPOTION OF THE COMPETED FOR THE SHARL DEPOTION OF T |

| _ | | FOR 1 - STATE REGISTRAR | STATE OF I | MARYLA | | EPARTI ITIFIC | | | | | MENTAI | L HYGIEN | E | ۲. | .03/1 | |
|---------------------------------------|-------|--|---------------------------|---|-------------------|---------------------------------------|------------------------|--------------|------------------|---------------------------------------|---------------------------|------------------------------------|-----------|-------------------------|--|----------|
| | | 1. OECEDENT'S NAME (First, Middle, Last) STANLEY STOCKER | | | | | | | | | 2. DATE | OF DEATH | AY 1 | 994 | 3. TIME OF OEATH 18:00 | м |
| | | 4. SOCIAL SECURITY NUMBER 452-42-0301 | 5. SEX | 6. AGE (In | yrs. lest birt | - | F UNDER 1 | YEAR DAYS | HOURS | R 24 HRS. MIN. | 7. DATE (Month Feb. | о г вигтн 8, 192 | 23 | 6. BIRT Coun Mass | HPLACE (State or Foreignity) Sachusette | m S |
| - | CIOR | 90. FACILITY NAME (If not institution, give str JOHNS HOPKINS HO | | | | | | | | | | DEATH | | | | |
| 8 | DINEC | 100. STATE 100. COUNTY Maryland Howar | d Count | У | 10 | 0c. CITY, 1 E11i | | | | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| 1 | HAL | 100. STREET AND NUMBER 4814 ROlligtop Ro | nad | | | | | 10f. | ZIP COD 2104 | | | | 10g. CIT | | WHAT COUNTRY? | |
| 200 | N N | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDEN | | | | | | 14. RAC | CE — American indien, ck, white, stc. | | | | | | |
| 100 | 5 N | 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) | | 1 | (Give k | ENT'S US kind of work NOT use n | k done du retired.) | iring mos | N at of worki | ing | 16b. | KIND OF BUS | | | ministrati | on. |
| d at once. | | 17. FATHER'S NAME (First, Middle, Last) Stanley Mar | shall St | 16. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | Pres | scott | | | | | |
| TO DE | | 190. INFORMANT'S NAME (Type/Print) Ms. Lorelei V. Sto | cker | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip or Cher 4814 Rolligtop Road, Ellicott City, | | | | | | | | 21043 | | | | |
| r must b | | 20b. PLACE AND OATE OF DISPOSITION 1 Burlet 2X Cremelion 3 Removal from Stale 20b. PLACE AND OATE OF DISPOSITION (Name of cemetery, crematory or other place). Baltimore—Washington Crem. 9-7-94 Laurel, MD | | | | | | | | | | | | | | |
| i examiner must be notified | | Slack Funeral Home, P.A. Ellicott City, Maryland 21043 | | | | | | | | | | | | | | |
| ent, the medical | | 23. PART I. Enter the diseasee, pr complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, ahock, pr heart fellure. Ust pnly one cause on each line. IMMEDIATE CAUSE (Finel disease pr condition resulting in death) PUE TO (OR AS A CONSEQUENCE OF): Approximata Interval Betw Onset and Dr. Conset and | | | | | | | | | | | | reen eath | | |
| injury, or other traumatic event, the | | resulting in death) DUE TO (OP AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that inkitoted eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | ٨ | | | |
| shows any injury, | 1000 | PART II. Other significent conditions | contributing to | death but | npt reeu | illing in t | the und | erlying | ceuse | given in | Pert i. | 24a, WAS AN PERFOR | MED? | 241 | b. WERE AUTOPSY FINDIP AMILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? | |
| SICIAN. | | DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | BUTE TO CA | | DEATH PLACE OF | F DEATH (| (Check or | | UNC | CERTAIN | V 🗆 | | | _ | | |
| PHYS. | | 1 VES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending | 28a. DATE OF (Month, D | INJURY | | | F 2 | 8c. INJU | IRY AT | | 6 Other | (Specify) | NJURY OC | CURED | | \dashv |
| TED BY | | 2 Accident investigation 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE O building, | F INJURY — etc. (Specify) | At home, | Jarm, stree | et, factor | | ES 2 | NO | 261. LOCA | ATION (Street a or Town, State) | nd Number | r or Rural | Route Number, | |
| COMPLET | | 29a. CERTIFIER (Check only one) CERTIFYING PHYSIC DOWN ONE) 2 MEDICAL EXAMINER | | | | | | | | | | | | | s) and menner as atated | d. |
| O BE COMPLE | | 29b. SIGNATURE AND TITLE OF CENTIFIER | | M. | 4-10 | | | | | ENSE NUM | 415.41 | | | E SIGNE | (Month, Day, Year) | |

Tower

32. REGISTRAR'S SIGNATURE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MA

DHMH-16 Rev 1/89

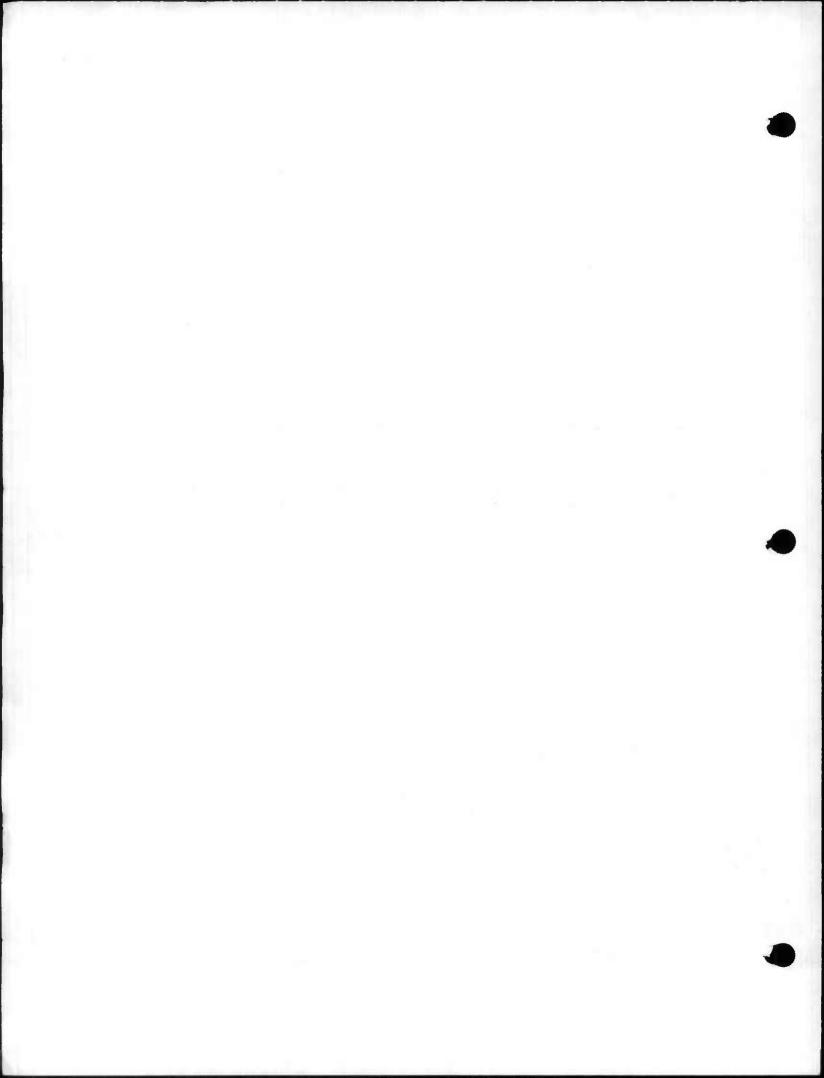
BALTIMORE, MARYLAND 21203-3146

TTENDING PHYSICIAN: The law requires that the death certificate be executed within DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| ched for use as the burtal-transit permit. Pages 1, 2, 3 shoul | 4 | TO BE COMPLETED BY FUNERAL DIRECTOR |
|--|---|-------------------------------------|
| should be deta | otified at onc | TO BE CO |
| or, page 5 | n eq Isi | |
| al direct | ner mt | |
| e funera | exami | |
| this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | rked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | PHYSICIAN: MEDICAL CERTIFICATION |
| SE | 9 | 0 |

| STATE | 0F | MARYLAND | 1 | DEPARTMENT | 0F | HEALTH | AND | MENTAL | HYGIENI |
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| | | C | E | RTIFICATE | 0 | F DEAT | ГН | | REG. NO. |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | | RTMENT OF H | | MENTAL HYGIEN | | | ì | | |
|--|---|--|---------------------------------|--|-----------------------------|---|--|---|---|--|--|
| | 1. OECEOENT'S NAME (First, Middle, Last) | SIMM | 3 | | | 2. DATE OF DEATH MONTH | 4 4 | an 0945 A | м | | |
| | 4. SOCIAL SECURITY NUMBER 549–05–6883 | 5. SEX 6. AGE (In | yrs. last birthday) 2 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) April 22, | 1912 | BIRTHPLACE (State or Foreign Country) California | | | |
| TOR | 99. FACILITY NAME (If not institution, give s Howard County Ge: | | 1 | ob. CITY, TOWN C | PR LOCATION OF DE | ATH | 9c. COUNTY Howar | of DEATH rd County | | | |
| DIRECTOR | residence of decedent 100. STATE 100. COUNT Maryland Howa | rd County | 10c. CIT | TY, TOWN OR LOCAT | ott City | , | 10d. INSIDE CITY LIMITS? 1 YES 2 TH NO | | | | |
| FUNERAL | 100. STREET AND NUMBER 3281 St. John's Li | ane | | 101 | ZIP CODE 21042 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | |
| B | 11. MARITAL STATUS 1 Never Merried 2 1 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT | | If yes, sp | | HIC ORIGIN? (Specify Yen, Puerlo Ricen, etc.) | | . RACE — American Indian, Black, White, etc. Specify: White | | | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondery (0-12) | completed) College (1-4 or 5+) | (Give kind of life. Do NOT u | s usual occupation work done during mo use retired.) [/Design | | 16b. KIND OF BU | | ГЯУ | | | |
| | 17. FATHER'S NAME (First, Middle, Last) Walter E. Simms | | | , | | ME (First, Middle, Meider la Roberta | | 9 | 1 | | |
| TO BE | 190. INFORMANT'S NAME (Type/Print) Ms. Beulah B. Sim | ms | | | | Route Number, City or Ton Ellicott | | | | | |
| | 20e. METHOD OF DISPOSITION 1 | | | e Washing | | | ocation — chy 6/94 I | Laurel, MD | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | Slark | M0053 | Slac | | ouny 1 Home, P 2y, Maryla | | 1043 | | | |
| | 23. PAFT I. Enter the diseases or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | List only one ceuse on ea | ich line. | | | | olratory errest, | Approximate Interval Between Onset and Deat | | | |
| CERTIFICATION | disease or condition resulting in death) Due to (or as a consequence of): My o Cashell infactory B. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | |
| CERTIF | that initiated events resulting in desth) LAST | d | | , , , , , , , , , , , , , , , , , , , | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other algolificant condition | na contributing to death bu | it not resulting | In the underlyin | g cause given in | | RMED? | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES | | | |
| SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 KNO. | HORPITAL | ADD II C FORE | OTHER: | LACE OF DEATH (Ch | | | | | | |
| | 27. MANNER OF DEATH | 29a. DATE OF IN SIZE (Month, Dily, War) | 26b. TH | ME OF 255 ME | FURITY AT DRIKTY YES 2 NO | 6 Other (Specify) 28d. DESCRIBE HOW | INJURY OCCUR | RED | | | |
| TED BY | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 26s. PLACE OF INJURY building, stc. (Speci | Az home term | street, factory, offic | 10 | 281. LOCATION (Street City or Town, State | end Number of | Rural Route Number, | | | |
| 3 Suicide 6 Could not be determined City or Town, State) 20e. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) and manner as stated. Chy or Town, State) Chy or Town, State) Chy or Town, State) | | | | | | | | | | | |
| TO BE C | 296 SIGNATUME AND TITLE OF CERTIFIE | | | | 29c. LICENSE NUI | | 29d. DATE SI | SIGNED (Morith, Day, Year) | | | |
| 7 | 30. NAME AND ADDRESS OF PRISON WI | Mo # 210 | ATH (ITEM 27) (Typ //05 | 18, Print) Littl | le Patu, | xent Pk | Co (| Unis 2 Mp | | | |
| | 31. DATE FILED (Month, Day, Year) SEP 0 8 1994 | 32. REGISTRAR'S SIGNA | ATURE | | | | | | | | |



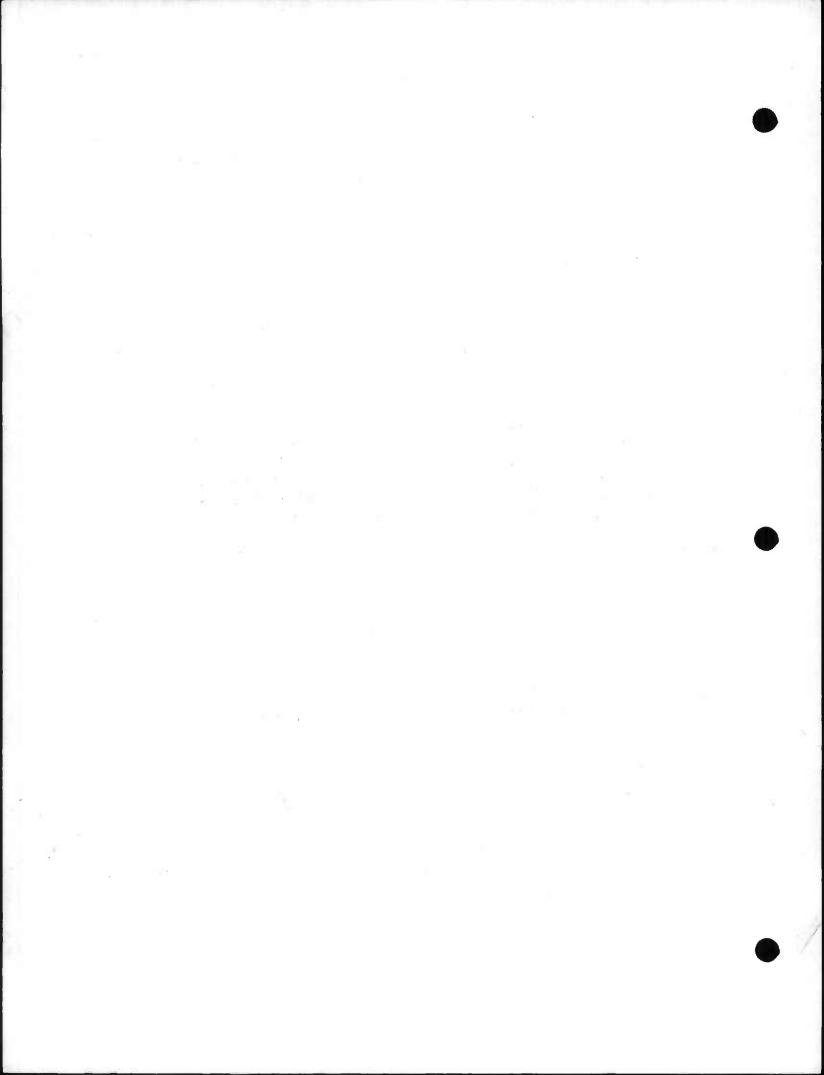
sician. ial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, Annual Parsacian: The law requires

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| quires man the dearn cermicate be executed within a nouns after dearn. Page 6 may be retained by the hospital or attending pi | npietely fi | if Health and Mental Hygiene prior to burial, cremation, or removal. |
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| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND | MENTAL HYGIENI |
|--|----------------|
| CERTIFICATE OF DEATH | REG. NO. |

| | | FOR 1 - STATE REGISTRAR | STATE OF MARYL | | RTMENT OF H | | MENTAL HYGIENE REG. NO. | | 773 | | | |
|---|-------------|---|--|---------------------------------|--------------------------------------|--------------------------------------|---|--|-------------|--|--|--|
| | | 1. DECEOENT'S NAME (First, Middle, L | TEL E.S | KINNE | R | | 2. DATE OF DEATH MONTH DAY | YEAR 3. TIME OF | OEATH 30A M | | | |
| , | | 4. SOCIAL SECURITY NUMBER | | (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BIRTHPLACE (Store | | | | |
| 19 | | 220-16-5547 | 1 🗆 M 2 🔀 F | 82 YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) 08-25-12 | WEST VIRG | | | | |
| 3 should | _ | 9e. FACILITY NAME (If not institution, g | | | | OR LOCATION OF DE | | c. COUNTY OF DEATH | | | | |
| 2, | DT: | NORTH WEST HOSE | | | RANDA | ALLSTOWN | | BALTIMORE | | | | |
| sades | DIRECTOR | 10a. STATE 10b. CO | JNTY | 10c. CI | 10c. CITY, TOWN OR LOCATION 10d. | | | | | | | |
| A. P. | | MARYLAND 100. STREET AND NUMBER | CARROLL | | HAMPS' | | | LIMITS: | 2XX NO | | | |
| physician. burial-transit permit. Pages 1, | FUNERAL | 2546 OLD FORTSO | HOOL HOUSE ROA | AD. | 101 | . ZIP CODE | and the second | CITIZEN OF WHAT COUNTS | RY? | | | |
| physician. burial-trar | N D | 11. MARITAL STATUS | 12. WAS DECEDENT EVER I FORCES? 1 YES | N U.S. ARMED | | | IC ORIGIN? (Specify Yee or No- | U.S.A. 14. RACE — American Black, White, etc. | Indien, | | | |
| ling phy the bur | ВУ Б | 1 Never Married 2 Merried 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR D | ATES XNO | | ocity Cuben, Mexica 2X NO Specify | n, Puarto Rican, stc.) | Specify: WHI | יבוידי | | | |
| use as t | <u>a</u> | 15. DECEDENT'S | | 16a. DECEDENT'S | USUAL OCCUPATION | ON | 16b. KIND OF BUSINESS | UNDUCTON | 115 | | | |
| for us | E | (Specify only highest g Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of life. Do NOT u | work done during mo ise retired.) | st of working | No. of Contract | ANDOS INT | | | | |
| the hospit detached once. | MPL | 8 17. FATHER'S NAME (First, Middle, Last, | | HOME | MAKER | | OWN | HOME | | | | |
| be de | E CO | PHILLIP S. EVAN | | | | | ME (First, Middle, Maiden Surner. O BRIEN | 10) | 400 | | | |
| 5 should | 00 | 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | G ADORESS (Street e | | Route Number, City or Town, State | Zip Code) 21074 | | | | |
| ay be rel page 5 | 욘 | WILLIAM E. SKIN | NER (SON) | 2546 | OLD FORT | SCHOOL HO | OUSE ROAD HAM | PSTEAD MARY | LAND | | | |
| director, pi | | 20e. METHOD OF DISPOSITION 1 | Removal from State Cen | netery, crematory or o | OF DISPOSITION (Na other place) | | | I — City or Town, State | TAND | | | |
| Page al dire | | 21. SIGNATURE OF FUM RAL SERVICE | E LICSUSEE | TRO CRE | | 09-10-94 NO AOORESS OF FA | | VILLE, MARY | LAND | | | |
| death. Pag funeral di l. examiner | | himues | with | | | | SELL C WITZKE | | | | | |
| iours after death. Page 6 may be retained by the hospital or attending d in by the funeral director, page 5 should be detached for use as the or removal. medical examiner must be notified at once. | | 23. PART i. Enter the diseases, | or complications that cause ire. List only one cause on a | d the death. Do | not antar tha mo | da of dying, such | LS ROAD COLU | arreat, Appro | oximata | | | |
| filled in the me | | IMMEDIATE CAUSE (Finel disease or condition | Pneumo | | | | | Onset | al Batween | | | |
| completely ial, cremati event, t | | reaulting in death) | a | CONSEQUENCE O |)F): | | | 18 | day | | | |
| and com o burial, o | z | Sequentially list conditions, | | | | | | | | | | |
| | RTIFICATION | If any, leading to immadiate cause. Enter UNDERLYING | DUE TO (OR AS | CONSEQUENCE C | PF): | | | | | | | |
| ertificate be ng physician giene prior t other traus | FIC | CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| endi Hy | ERTI | resulting in daath) LAST | | | | | | | | | | |
| 0 65 = | AL CEI | PART II. Other significent condi | tions contributing to death b | out not reaulting | In the undarlying | g cause given in | Part I. 24s. WAS AN AUTOP | SY 24b. WERE AUTOP | SY FINDINGS | | | |
| | MEDICA | | | | | | PERFORMED? | AVAILABLE PO COMPLETION OF DEATH? | | | | |
| requires been sign of Heat | ME | DID TORACCO HEE | CONTRIBUTE TO | CALLES OF | TO 10 A 100 A 1 A 4 | | _ | 1 TES 2 | (I) NO | | | |
| NB PAYSACIAN: The law requires that the transfer has been signed by the transfer has been signed by the transfer has been some any marked, or flem 23 shows any | SICIAN: | DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICA | | CAUSE OF | | ACE OF DEATH (CH | Mr. contr. const | , | | | | |
| SHOAN: The law crificate has law State Dept | SIC | EXAMINER? | HOSPITAL: 1 Pinpatient 2 ER/Out | patient 3 DOA | OTHER: | e 5 🗆 Residence | | | | | | |
| Mis cert with the | РНУ | 27. MANNER OF BEATH 1 Natural 5 Pending | 26e. DATE OF INJURY (Month, Day, Year) | 28b. TIR | AE OF 26c. INJ | | 28d. DESCRIBE HOW INJURY | OCCURED | | | | |
| | ВҮ | 2 Accident Investigat | on 26e. PLACE OF INJURY | At home form | | YES 2 NO | | | | | | |
| THE PERSON | TED | 3 Suicide 6 Could not 4 Homicide determine | building, atc. (Spe | cify) | street, ractory, offic | | 281. LOCATION (Street and Num City or Town, State) | nber or Hural Houte Number, | | | | |
| Pours. | PLET | 290. CERTIFIER (Check only | HYSICIAN: To the beat of my know | riedge, death occur | red at the time, date | end place, and due | to the cause(s) end manner es | stated. | | | | |
| MIT: II | COMPL | | MINER: On the beele of axamination | | | | | | as stated. | | | |
| TO THE HOSE TO THE FLANE De filed within | BE | 294 SKINATURE AND TITLE OF CERT | FIE | | | 29c. LICENSE NUA | IBER 29d. | DATE SIGNED (Month, Day, | | | | |
| E E S W | 인 | 30. NAME AND ADDRESS OF PERSON | WHO COMPLETED CAUSE OF OR | ATH (ITEM 27) (Toro | 9. Print) | V 404 | 91 D | 09.07.19 | 46 | | | |
| | | Sixed M. A. | Ricz N. | W.H.C | Ran | dals 7 | rum 2113 | 3 | | | | |
| 0 1 | | 31. SEP (18 1994) | 1 32 AEGISTRAR'S SIGN | IATURE | | | | | | | | |
| | | | Juli Danden - Ra | - Lane | | | | | | | | |



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

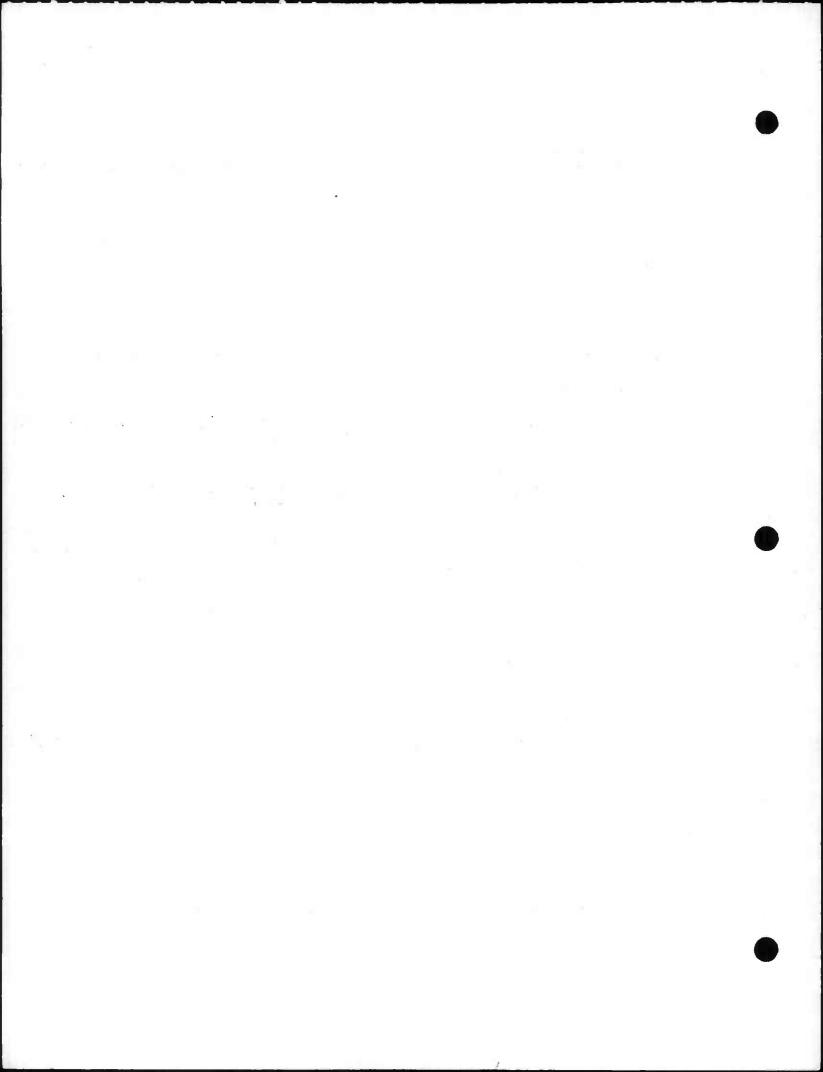
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

| | FOR STATE REGISTRA |
|---|--------------------------|
| | 1. DECEDENT'S N |
| | |
| I | 1. SOCIAL SECUR |
| , | 90. FACILITY NAM |
| | Memorri a |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CERTIFIC | ATE OF DE | ATH | REG. | NO. | | | | | |
|---------------|---|---|--|------------------------------------|---------------|---|----------------------------|--|--|--|--|--|
| 127 | 1. DECEDENT'S NAME (First, Middle, Last) | OCTUTA | | STULL | | 2. DATE OF DEATN SEPT 1 DAY 1994 PAR 9:45 | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. 149-34-4131 1 | I □ M 2 💢 F | r yrs. lest birthday) # | | INDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Yea | 6 | BIRTNPLACE (State or Foreign Country) Neather I give | | | | |
| CTOR | 99. FACILITY NAME (If not institution, give street and number) Memorial Hospital at Easton RESIDENCE OF DECEDENT 99. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DI Talbot Talbot | | | | | | | | | | | |
| DIRECTOR | 10e. STATE 10b. COUNTY | | 10c. CITY, TO | Verals | bur | 3 | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | | |
| FUNERAL | 219 Vesper (- | N OF WHAT COUNTRY? | | | | | | | | | | |
| B⊀ | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced | 2. WAS DECEDENT EVER IN FORCES? 1 ☐ YES IF YES, GIVE WAR OR DAT | 2 NO | 13. WAS DECENDED If yee, specify (| Cuban, Mexice | IIC ORIGIN? (Specify n, Puerto Ricen, etc. | Yee or No 14 | Black, White, etc. Specify: White | | | | |
| COMPLETED | | mpleted) College (1-4 or 5 +) | Itte. Do NOT use re | done during most of w tired.) | vorking | | BUSINESS/INDUS | STRY | | | | |
| MP | STACE PERCE | None | Super | visor | | House | keeping/ | / Hotel | | | | |
| BE CO | ANTONIUS HOCK | lenaars | | Mo | aria | ME (First, Middle, Me Hage | man | | | | | |
| 2 | 19a, INFORMANT'S NAME (Type/Print) | ti. 11 | 219 V | DRESS (Street and Nu | | noute Number City or | Town, State, Zip Co | nde) | | | | |
| | 20e. METNOD OF DISPOSITION 1 | | PLACE AND DATE OF Ditery, crematory or other | | 11021 | | LOCATION — CIR | y or own, State | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENS | see Ronald We | ade, DiR | 655U | DRESS OF FAC | Show or c | e Anat | Himae MD | | | | |
| | 23. PART I. Entar the diseasee, or com shock, or heart failura. List | nplications that caused it only one cause on ea | the deeth. Do not | anter the moda of | dying, suci | h aa cardlac or ra | apiratory arres | Approximate | | | | |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) • CARDIO GENIC 5170C14 DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| TION | Sequentially list conditions, if eny, leeding to immediate Due to (or as a conscouence of): | | | | | | | | | | | |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | | |
| CE | d. | | | | | | | | | | | |
| DICAL | PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF | | | | | | | | | | | |
| PHYSICIAN: ME | DID TOBACCO USE CONTRIB | BUTE TO CAUSE OF | DEATH YES | □ NO 🔯 U | NCERTAIN | - I | | 1 YES 2 NO | | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | QSPITAL: | 8. PLACE OF DEATH (| Check only one) | | | | | | | | |
| 4YS | 1 VES 2 NO 1 | Inpatient 2 ER/Outpat | tient 3 DOA 4 | Nursing Nome 5 | | | | | | | | |
| ВУ Р | 1 Natural 5 Pending Investigation | | | | | | | | | | | |
| ETED | 3 Suicide 6 Could not be determined | 28e. PLACE OF INJURY - building, atc. (Specif | — Ar home, farm, atrea y) | it, fectory, office | | 28f. LOCATION (Str City or Town, S | eet and Number or tate) | Rural Route Number, | | | | |
| COMPLETED | | On the beels of examination | | | | | | Couse(a) and manner oo stated, | | | | |
| TO BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | fram 17 | D | | DOO 2 | _ | 29d. DATE S | GIGNED (Manth, Day, Year) | | | | |
| | 30. NAME AND ADDRESS OF PERSON WHO C | IN, 410 | E. DOV | | 1157 | m, 1 | D, 21, | (0) | | | | |
| | 31. DATE FILED (Month, Day, Year) CFD 8 1994 | 32 REGISTRAR'S SIGNAT | Rodall | į. | | • | | | | | | |



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DIVISION OF VITAL RECORDS, P.O. BOX 687

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Jours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAN | | | (11)() | CATE | L DEW | 111 | HE | G. NO. | | | |
|---------------|---|---|------------------|--|----------------------|-------------------|-------------------------------|-------------------------------|--------------|--------------------------|-------------|---------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 70 P | | 2. DATE OF DEATH MONTH | | | | DAY YEAR 3. TIME OF DEATH | | | | |
| | JAMES K. | | | OSS SHI | | | 9 | 3 | 94 10145 A N | | | |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. last | birthday) | IF UNDER 1 YEAR | | HOURS MIN. (Month, Day, Year) | | | 8. BIRTHPLACE (Country) | | ACE (State or Foreign |
| | 487-14-8610 | 1 🔀 M 2 🗆 F | 74 | YRS. MONTHS DAYS HOURS MIN. (MONTH, Day, Year) | | | | | | 0 | MISS | OURI |
| | 9e. FACILITY NAME (If not institution, give s | treet end number) | | | 9b. CITY, TOW | N OR LOCAT | | | | | Y OF DEAT | |
| 뜅 | LAUREL REGIONAL H | OSPITAL. | | | | LAURE | 'T | | | DD | TNCE | GEORGE |
| 5 | RESIDENCE OF DECEDENT | ODITINE | | | | LAUKE | ,11 | | | IK | INCE | GEURGE |
| DIRECTOR | t0e. STATE 10b. COUNTY | 1 | | 10c. CITY | TOWN OR LO | CATION | | | | | 10 | d. INSIDE CITY |
| <u>a</u> | MARYLAND ANN | E ARUNDEL | - 1 | | | LAURE | I. | | | | 1 | LIMITS? YES 2 X NO |
| 7 | 10e. STREET AND NUMBER | | | | | 101. ZIP COD | | | - 15 | 10g. CITIZE | | AT COUNTRY? |
| FUNERAL | 246 SPRING GAP SO | ווידע | | | | 20724 | | | | | | |
| Ξ | 11. MARITAL STATUS | 12. WAS DECEDENT EVER I | NIIS ADM | ED. | 12 480 | | | IC ORIGIN? (Spe | 14 14 | US. | | |
| | 1 Never Married 2 Merried | FORCES? 1 YES | 2 NC | | If yes, | specify Cubi | nn, Mexican | , Puerto Ricen, | etc.) | No- 1 | Black, W | American Indian, Yhite, etc. |
| | | | | | | | | | | WHITE | | |
| | | | | | | | | | | | | |
| COMPLETED | (Specify only highest grade | completed) | (Give | e kind of w | ork done during | most of worki | ing | 100. KIND | OF BUSIN | ESS/INDU | SIRY | |
| | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) College (1-4 or 5 +) | | | | | | | | | | | |
| Z | 11 | Ø | <u> </u> | SAFE | TECH | | | | Repa | | | |
| 응 | 17, FATHER'S NAME (First, Middle, Last) | | | | | 18. MOT | HER'S NAM | AE (First, Middle, | Maiden Sur | mame) | | |
| BE | CARL SHEPLER | | | | | U | NKNOV | V N | | | | |
| 10 | 19e. INFORMANT'S NAME (Type/Print) | | 196. | MAILINO | ADDRESS (Stre | et and Numbe | r or Rural A | oute Number, Cit | y or Town, S | Stete, Zip C | Code) | |
| F | RICHARD A. SHEPLE | R, SR. | 65 | 08 E | ENGEL I | RIVE, | McLI | EAN, VI | RGIN | IA : | 22101 | |
| | 20e. METHOD OF DISPOSITION | | . PLACE AN | DDATEO | F DISPOSITION | | | | 20c. LOCAT | | ty or Town, | State |
| | 1 Burial 2x Cremation 3 Rem 4 Donation 5 Other (Specify) | | netery, crem | etory or off | ner place) UACHTN | CTON | СВЕМ | 0/33 | TATT | DET | MADS | T A NID |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 23. SIGNATURE OF FUNERAL SERVICE LICENSEE 24. DORIGHOUT S. OCT. SPECIAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY FLECK FUNERAL HOME, I | | | | | | | | | | | |
| | D 6 0000 | * (bahh | | | 7.0 | 7 (1.1) | D11 G1 | | | | | |
| | · Lines | Juliense | 1 | | | | | | | | | MD 20707 |
| | 23. PART I Enter the diseases, or cahock, or heart fellure. | complications that ceuse | d the dea | th. Do no | ot enter the | node of dy | ing, such | as cardiac o | r respirat | ory arres | st, | Approximate |
| | IMMEDIATE CAUSE (Final | Clist Only One bause on | A | | | 9 | | | | | | Interval Between Onset and Death |
| | disease or condition | (DNG | 50- | FIN | 15 | HFA | RT | FA | 410 | RE | , | |
| | disease or condition resulting in desth) a. ON GESTIVE HEART FALIURE Onsat and Death Due to (or As A consequence of): | | | | | | | | | | | |
| - | | CORON | ALX | 1 1 | 1271 | RY | 0 | PISE | 1 PF | > | | i |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| ¥ | cause. Enter UNDERLYING | RENAI | 1- | CAI | INR | 6 | | | | | | |
| E | CAUSE (Disease or injury that initiated events | DUE TO (OR AS | CONSECU | JENCE OF |): | K | | | | | | 1 |
| E | resulting in deeth) LAST | RENE | 1/ | / A | Rein | ma | 1 | | | | | |
| H | | d/ | 1 | | 1-0114 | 017 | T | | | | | |
| | PART II. Other algnificent condition | s contributing to death b | out not re | sulting Ir | the underly | ing ceuse | given in F | | WAS AN AU | | | ERE AUTOPSY FINDINGS |
| EDICAL | DIA | B5-T55 | ME | 7/1 | 1-10 | 9 | | | PERFORME | | CC | MILABLE PRIOR TO MPLETION OF CAUSE |
| 요 | 317 | | | | | | | _ ' | YES 2 | NO | | DEATH? |
| Σ | DID TOBACCO USE | CONTRIBUTE TO | CALIS | E OE | DEATH | VEC I | T NO | | | | 1 | ☐ YES 2 ☐ NO |
| A I | 25. WAS CASE REFERRED TO MEDICAL | CONTRIBUTE TO | CAUS | E OF | _ | |] NO | | | | | |
| PHYSICIAN: | EXAMINER? | HOSPITAL: | | | OTHER: | PLACE OF E | | | | | | |
| ĭ. | 1 VES 2 NO | 1 Inpetient 2 I ER/Out | patient 3 | | | | Y | Other (Spec | | | | |
| 표 | 27. MANNER OF DEATH 1 Natural 5 Pending | (Month, Day, Year) | | 28b. TIME INJU | | NJURY AT WORK? | | 28d. DESCRIBE | HOW INJU | URY OCCU | RED | |
| B | 2 Accident Investigation | | | | | YES 2 | NO | | | | | |
| | 3 Suicide 8 Could not be | 28e, PLACE OF INJURY building, etc. (Spe | f — At hom cify) | e, ferm, st | reet, factory, o | fice | | 28f. LOCATION City or Town | (Street and | Number of | Rural Rout | a Number, |
| | 4 Homicide determined | | | | | | | | ,, | | | |
| 7 1 | 29e. CERTIFIER | CIAN: To the beat of my know | rledge, dest | h occurre | at the time. | ate end place | end due t | to the cause(s) | and menne | r en stated | | |
| COMPLET | | R: On the basis of exemination | | | | | | | | | | od manner se stated |
| 8 | | | | 40 | | | | | | | | |
| H | 29b. SIGNATURE AND TITLE OF CERTIFIER | W Sod | | Alte | el Ay | 29c. LIC | ENSE NUM | BER | 2 | 9d. DATE | SIGNED (M | onth, Day, Year) |
| 0 | | 0'' | | 1 4/ | 1 | رلا | 17 | 077 | | - 9 | ,59 | 4 |
| - | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF DE | ATH (ITEM | 27) (Type, | Print) | 2011 | 1111 | 6050 | SUR | 677 | 0 | 220772 |
| | V. 51961- | 12044 | HAO | VOV | 21 | 11-KC | 4 47 | UNZT | 10.0 | EL/ | M | 12/10 |
| | 31. DATE FILED (Month, Day, Year) | all abudear ha | A Party | | | | | | | | | |
| | SEP 0 8 1994 A | RUM ANDUNGER WA | (Aller) | | | | | | | | | |
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use as the burial-transit permit. Pages 1, 2, 3 should Page 6 may be retained by the hospital or attending physician. al director, page 5 should be detached for use as the burial-tran rurs after death. n by the removal. filled in by t 5 completely filled rial, cremation,

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CERTIFICATION

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31. DATE FILED (Month, Day, Year)

0 8 1994

QUINUM JA

32. REGISTRAR'S SUBATURE

and com traumatic

n signed by the attend f Health and Mental H Injury,

prior to

BALTIMORE, MARYLAND 21215-0020

FUNERAL

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certificate be executed with that requires The law I

TAL RECORDS, P.O. BOX 68760,

has been of P Dept. of P ate OR ATTE HOSPITAL FUNERAL within 72 I TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT: If

Item#1,10c Film# G-715 09/08/94 R.M. 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH BONNIE KATHLEEN VETTERS 3. TIME OF DEATH YEAR BONNIE VETTERS 09 10:21 1994 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH S. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 235-30-4102 71 DAY8 12/26/22 West Virginia 1 M 2 X F YRS. 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR Greater Baltimore Medical Center Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Towcon 1 YES 2 NO TIMONIUM 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? 202 Coralhaven Court 21093 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or No If yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married 1 YES 2 NO Specify. Specify: 3 Widowed 4 Divorced White 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) (Specify only highest grade comple Elementery/Secondary (0-12) College (1-4 or 5+) Registered Nurse 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Harry Eye Annie Μ. Martin 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Charles E. Vetters same as #10a - #10f 20a. METHOD OF DISPOSITION
1

© Burlel 2 □ Cremation 3 □ 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE Dullaney Valley 9/10/94 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. Ernst Level III 1050 York Rd., Towson, Maryland 21204

23. PART I. Eafer the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approx Approximata shock, or haart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Daath disease or condition Jente Myorardel 1 hour resulting in death) Sequantially list conditions, OUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? CODD. /As the 1 YES 2 7 NO Hypa tensin 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Imperient 2 | ER/Outpetient 3 | DOA OTHER: 1 TYES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF GEATH 28a. DATE OF INJURY 26c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1e Natural 5 Pending 1 YES 2 NO 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 4 Homicide 29e. CERTIFIER (Check only one)

2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) end manner as stated, 206. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D-12550 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

YOUKND

TOUSON, ND

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which are the same of the

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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| TENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending p | LONECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the b | I after death with the State Dept. of Health and Mental Hygiene prior to burial, cramation, or removal. | Um 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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29b. SIGNATURE AND TITLE OF CERTIFIER

SEP 0 8 1994

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27), (Type, Print)

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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH WISCOSKEY SEP YEAR MARIE 94 1335 Velma 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year)
Nov. 8, 5 SEX IF UNDER t YEAR IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign 219-30-9280 1 M 2 T 91 YRS. 1902 Virginia 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Northwest Hospital Center Randallstown Baltimore RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Randallstown 1 TYES 2 TO NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5412 Old Court Road 21133 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 NO If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 Never Married 2 Married Specify. White ВУ 1 YES 2 X NO Specify: 3 🔀 Widowed 4 🗌 Divorced COMPLETED 15. DECEDENT'S EDUCATION t6a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 166. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) 11th grade St. Agnes Hospital Gift Shop worker 17. FATHER'S NAME (First, Middle, Last) ts. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown Crenshaw Unknown t9a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. & Mrs. Milton Klepfish 3618 Blair Ave. Randallstown, MD 20a. METHOD OF DISPOSITION 20b. PLACEAND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata DATE 1 Denation 5 Nother (Specify) Entombment Loudon Park Mausoleum 9/2 Baltimore, MD 21. SIGNATURE/OF FUNERAL SERVICE LICENSEE, 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. ame 8728 Liberty Road Randallstown, MD 21133 21 PAHT Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between IMMEDIATE CAUSE (Final Onset and Death ESPIRATORY FAILURE disease or condition ____ Z DAY CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL AVAILABLE PRIOR TO COMPLETION DF CAUSE t 🗌 YES 2 🗀 DF DEATH? 1 - YES 2 - JUD PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL EXAMINER? OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Realdence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED t Accident м t YES 2 NO BY 28a. PLACE OF INJURY — At home, farm, streat, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 29a. CERTIFIER t CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the beals of axe stion and/or investigation, in my opinion, death occured at the time, data and piece, and due to the cause(a) and manner as stated.

29d. DATE SIGNED (Month, Day, Year)

DSEP

ALIENDING PHYSICIAN: The law requires that the death certificate be executed within mounts after death. Page 6 may be retained by the hospital or attending physician.

ECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should may after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. TO BE COMPLETED BY FIINFBAL DIBECTOR BALTIMORE, MARYLAND 21215-0020 am 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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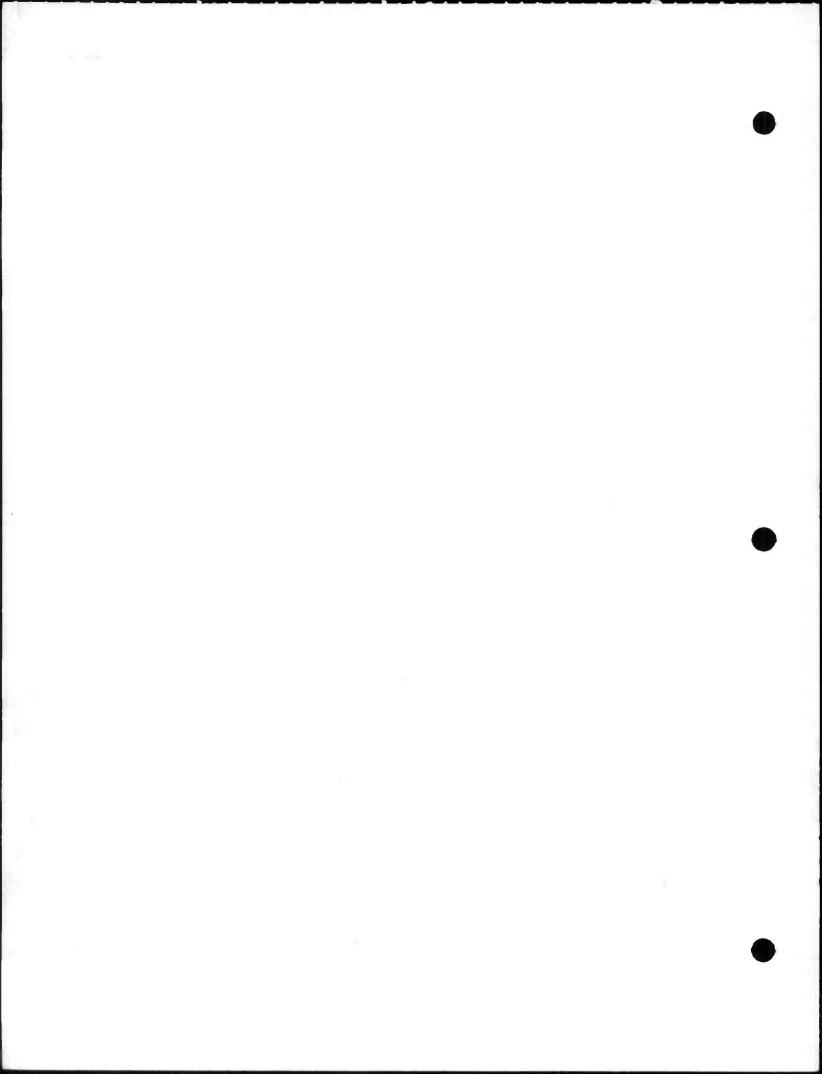
| | Item # 4 Fi. FOR STATE REGISTRAR | 1m # G 7 | 16 10-17- STATE OF I | MARYLANI | Per Fu D / DEPAF CERTIF | RTMENT | r of h | EALTH | | MENTA | L HYGIEN | E | | | | | |
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| Į, | 1. DECEDENT'S NAME (First | t, Middle, Last) | | | | | | | | 2. DATE | OF DEATH | | | 3. TIME OF DEATH | | | |
| | | | Helen N | I. Wnu | ık | | | | | | tember | | 994 | 9:45a.m. M | | | |
| 0.835 | 4. SOCIAL 219-07- 209-07-8890 | s. lest birthday) YRS. | IF UNDER MONTHS | DAYS | IF UNDER | MIN. | (Mon | of BIRTH th, Day. Year) 20, 1 | - 1 | BIRTHPLACE (State or Foreign Country) | | | | | | | |
| 5 | 216 Hawthor | 99. FACILITY NAME (W not institution, give street end number) 216 Hawthorne Avenue | | | | | | | on of DI | EATH | | | 1tim | | | | |
| | RESIDENCE OF DEC | 10c. CIT | Y, TOWN | OWN OR LOCATION Pikesville | | | | 1 _e | | - 1 | 10d, INSIDE CITY LIMITS? | | | | | | |
| , | Maryland 100. STREET AND NUMBER | | е | | | 100 | ZIP COD | | | | 40~ CITIZ | | 1 YES 2 NO | | | | |
| 216 Hawthorne Avenue 21208 United States | | | | | | | | | tates | | | | | | | | |
| 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. RACE — Ameri 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 16. RACE — Ameri 16. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 16. RACE — Ameri 17. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 18. RACE — Ameri 19. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 19. WAS DECENDENT OR HISPANIC ORIGIN? (Specify Yes or No— 19. WAS DECENDENT OR HISPANIC ORIGIN? (Specify Yes or No— 19. WAS DECENDENT OR HISPANIC ORIGIN? (Specify Yes or No— 19. WAS DECENDENT OR HISPANIC ORIGIN? (Specify Yes or No— 19. WAS DECENDENT OR HISPANIC OR HI | | | | | | | | | | | | | | | | | |
| 15. DECEDENT'S EDUCATION 188. DECEDENT'S USUAL OCCUPATION 185. KIND OF BUSINESS (MUDICATOR) | | | | | | | | | | casian | | | | | | | |
| (Specify only highest grade completed) College (1-4 or 5 +) 12 th Waitress The Pimlico Hotel | | | | | | | | | | 1 | | | | | | | |
| | 17. FATHER'S NAME (First, M | fiddle, Last) | | | Walti | C33 | | 18. MOT | HER'S NA | | Middle, Maiden | | 11000 | | | | |
| 1 | | Wnuk | | | | | | | | Ver | onica | Ogoi | | | | | |
| 2 | Ben Zablons | | | | | | | | | | ber, City or Yow sville | | | Q | | | |
| | 20e. METHOD OF DISPOSIT | TION | | 20b. PLA | CE AND DATE | | | | ilue | DAT | | CATION — C | | | | | |
| | 1 N Buriel 2 Crematic 4 Donstion 5 Other | | oval from State | | | | | | mete | ry 9 | /10/94 | Balt | imor | e,Maryland | | | |
| | 21. SIGNATURE OF FUNERA | AL SERVICE LIC | ENSEE) | |) | 22. T | NAME AN | D ADDRE | SS OF FA | CILITY | ral Di | recto | re | TNC | | | |
| ì | 1 400 | aph | J. Kel | lno | N | | | | | | | | | 21133-4784 | | | |
| | 23. PART Photos that described in the shock, or has a second to the second that the second tha | eart fallura. | a. M.Hz. | tate | Ca o | | | | ing, suc | h as car | diac or respi | ratory arre | est, | Approximate Interval Batween Onset and Death | | | |
| | Sequentially list condit | tions. | b | (OR AS A COR | | F): | | | | | | | | | | | |
| | If any, leading to imme cause. Enter UNDERLY CAUSE (Disease or Inju | ING | c | | | | | | | | | | | | | | |
| | that initiated eventa resulting in death) LAS | т | DUE TO | (OR AS A COP | NSEQUENCE O | F): | | | | | | | | | | | |
| <i>j</i> | | | d | | | | | | | | | | | 1 | | | |
| | PART II. Other signification | | eve dus | | ot resulting | In tha ur | ndarlylng | j cauaa i | givan in | Part I. | 24a. WAS AN PERFOR | MED? | | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | |
| | Secral | decul | ties W | rer | | | | | | | () (23 2 | P NO | | OF DEATH? | | | |
| | _ DID TOBACC | O USE | CONTRIBUT | E TO CA | AUSE OF | DEA | TH Y | ES [|] NO | D 19 | | | | | | | |
| 25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 1 Netural 5 Pending 28. DATE OF INJURY (Month, Dey, Year) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) | | | | | | | | | | | | | | | | | |
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| | 3 Suicide 8 Could not be determined 28s. PLACE OF INJURY — At home, farm, street, factory, offics building, atc. (Specify) 28s. LOCATION (Street end Number or Rural Route Number, City or Town, State) | | | | | | | | | ute Number, | | | | | | | |
| | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es stated. 2 MEDICAL EXAMINER: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) end menner es stated. | | | | | | | | | | | | | | | | |
| | 2 MED | | R: On the besis of e | AMMINATION ONC | | | 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Morith, Day, Year) | | | | | | | | | | |
| | 2 MED | DICAL EXAMINE | | 7 | | | | _ | 1.0 | | > | | | | | | |
| | 2 MED | OF CERTIFIER | L WK | 7 | | | A ve | D- | 191 | 158 | | 29d. DATE | SIGNED | | | | |

Stelle Ber Walter Bridge Barrell

PIVISION OF VITAL RECORDS, P.O. BOX 68760,

| RATTENDING PHYSICIAN: The law requires that the death certificate be executed within yours after death, Page 6 may be retained by the hospital or attending physician. | HELIUR After ma certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be after the State Dept, of Health and Mental Hypiene prior to burial, cremation, or removal. | mm 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| JING PHYSICIAN: The law | After this certificate has b | marked, or Item 23 |
| R ATTEM | RECTOR uns after | m 28 is |

| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPART CERTIFIC | MENT OF A | REALTH AND N | MENTAL HYGIEN | | | | | | |
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| | 1. DECEDENT'S NAME (First, Middle, Last, | ' WEISS | | | | 2. DATE OF DEATH | 05 94 | 3. TIME OF DEATH | | | | |
| : | 4 SOCIAL SECURITY NUMBER 100–32–9474 | Co | RTNPLACE (State or Foreign unitry) WYORK | | | | | | | | | |
| TOR | 90. FACILITY NAME (If not institution, give Howard County Go | ATN | 9c. COUNTY O | F DEATN | | | | | | | | |
| DIRECTOR | | | | | | | | | | | | |
| FUNERAL | 100. STREET AND NUMBER 1007. ZIP CODE 1009. CITIZEN OF WHAT CO USA | | | | | | | | | | | |
| B⊀ | I TOTAL MATINA | | | | | | | | | | | |
| LETED | 15. DECEDENT'S EDUCATION 180. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | | | |
| E COMPLET | 17. FATHER'S NAME (First, Middle, Last) John J. Frieta | | ALC and | Music (| 18. MOTNER'S NAM | ME (First, Middle, Malden Steinmeye | , | | | | | |
| TO B | 190 INFORMANT'S NAME (Top/Digit) | | | | | | | | | | | |
| | 20a. METNOO OF DISPOSITION 1 Burlel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Baltimore—Washington Crematory Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility | | | | | | | | | | | |
| | 23. PART i. Enter the diseases, or | M00544 | Asha darah Da as | Ellic | cott City | Home, P., Marylan | d 21043 | | | | | |
| | shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. List Drily one cause on e | consequence of: | 1 | _ | | iretory errest, | Approximate Interval Between Onset and Death | | | | |
| CERTIFICATION | Sequentisity flat conditions, if sny, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | . Se | CONSEQUENCE OF): () () () () CONSEQUENCE OF): | | | | | | | | | |
| AL. | PART II. Other algorificant condition Polymy al | sins contributing to deeth b | ut not resulting In | the underlying | g csuae given in i | Part i. 24a. WAS AN PERFOR | RMED? | 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 | | | | |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE OF DEATH | | UNCERTAIN | | | | | | | |
| | 1 YES 200 NO 27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | | OF 28c, INJ | e 5 Residence (WRY AT RK? /ES 2 NO | B Other (Specify) 28d. DESCRIBE NOW I | NJURY OCCURED | / | | | | |
| ETED BY | 3 Sulcide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Spec | — At home, farm, str | eet, factory, offic | | 281. LOCATION (Street and City or Town, State) | and Number or Rur | si Route Number, | | | | |
| COMPLET | one) 2 MEDICAL EXAMIN | SICIAN: To the best of my knowl IER: On the bests of exemination | | | | | | e(s) and menner es stated. | | | | |
| TO BE (| 39. NAME AND ADDRESS OF PASON W | | ATN (ITEM 27) /Xmc 9 | Print) | 29c. LICENSE NUM | 7613 | 29d. DATE SIGN | (Month: Day, Year) | | | | |
| | 13 CONGER, | MO # 2-(0) | 110 | 22 7 | ittle Pa | typent | Pky | MO 2104 | | | | |
| | 31. DATE EILED (Month, Day, Year) SEP 0 8 1994 | Joseph Danison - Ro | | | | | / | | | | | |



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| P.O. BOX 68760 | ath certificate be executed with hours after death. Page 6 may be retained by the hospital or |
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DIVISION OF VITAL RECORDS,

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MID

Julia MAEGITTAR SIGNATURE

LANSDALE

| | permit. Pages 1, 2, 3 s | | |
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| al or attending physician. | and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit | | |
| hours after death. Page 6 may be retained by the hospital or attending | 5 should be detached for | | notified at once. |
| death. Page 6 may be | e funeral director, page | ï | natic event, the medical examiner must be notified at once. |
| 4 | completely filled in by th | to burial, cremation, or removal. | event, the medical |
| eath certificate be executed wi | he attending physician and | rtal Hygiene prior to buri | narked, or item 23 shows any injury, or other traumatic |
| IAN: The law requires that the death certificate | is certificate has been signed by the | fter death with the State Dept. of Health and Mental Hygiene prior to | 23 shows any injur |
| PHYSIC | JR: After this certificate | er death with the State | is marked, or item |
| TO THE HOSPITAL OR ATTENDING | TO THE FUNERAL DIRECTOR: / | be filed within 72 hours after | IMPORTANT: If item 28 is ma |
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94 26380 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR *MARJORIE* WALDMAN AUGUST 1994 6:54PMM 4. SOCIAL SECURITY NUMBER 181-20-7358 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 | M 2 | F 9/6/26 (Month, Pay, Year) PENNSYLVANIA 96. CITY, TOWN OR LOCATION OF DEATH 9e. FACILITY NAME (If not institution GREATER BALTIMORE MEDICAL CENTER BALTIMORE DIRECTOR RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OF LOCATION BALTIMORE 10d. INSIDE CITY BALTIMORE MARYLAND 1 YES 2 NO SA SHIZEN OF WHAT COUNTRY? FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 21208 7203 BROOKCREST WAY, APT. T-2 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—It yes, specify Cuban, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Merried BY WHITE 3 Widowed 4 NDivorced tee. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) RETAILER CLOTHING & GIFTS 17. FATHER'S NAME (First, Middle Last)
DR. ALBERT D. BLAND 16. MOTHER'S SAME (First, Middle, Melden SPETET BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 5 MRS. LESLIE FLEISHMAN 7704 GRASTY RD. BALTIMORE, MD 21208 24p. METHOD OF DISPOSITION
1-1-2 Burlel 2 Cregfetion 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE OHEBOTHALOMOMEM. PARK 9/2/94 REISTERSTOWN, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE SOLMELEVINSON FEIL BROS., INC. huan 6010 REISTERTOWN RD. BALTO., MD 21215 23. DART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, Approximate shock, or heart failure. Liet only one cause on each line Interval Between IMMEDIATE CAUSE (Finel Onset and Death disease or condition resulting in death) cardiopulmorary arrest 30 ent stage chronic obstructive lung disease 20 45 CERTIFICATION Sequentielly list conditions, OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO pulmonary mass COMPLETION OF CAUSE 1 - YES 2 -10 OF DEATH? diabeles mellitus 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES PHYSICIAN: NO | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** OTHER 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA ne 5 - Reeldence 8 - Other (Specify) 27. MANNER OF DEATH 26e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 26d. OESCRIBE HOW INJURY OCCURED 1 Matural WORK? 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, stc. (Specify) 3 Sulcide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 29e. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(e) end menner ee stated. GNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Jaur dale 9/1/94 D43936 Mux 7 111.

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PUVISION OF VITAL RECORDS, P.O. BOX 68760.

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| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | | TMENT OF HE | | MENTAL HYGIEN | _E 94 | 26381 | |
|--|---|---|---------------------------------------|-------------------------|-----------------|--|-----------------|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) Matthew | Am | ES | | | 2. DATE OF DEATH MONTH | 5 - 90 | YEAR S MM | |
| | SOCIAL SECURITY NUMBER 217-03-2380 FACILITY NAME (# not institution, give str | 1 X M 2 - F 8 | In yrs. last birthday) 7 YRS. | | F UNDER 24 HRS. | 7. DATE OF BIRTH (Morith, Day, Year) 04 09 | 07 | BIRTHPLACE (State or Foreign Country) Virginia | |
| DIRECTOR | Frederick Villa | | Iome | | imore (| | 9c. COUNT | Y OF DEATH | |
| | Maryland 10e. STATE 10e. COUNTY | Lander | 10d. INSIDE CITY LIMITS? 1X YES 2 NO | | | | | | |
| ERA | 912 N. Bentalou | Street | | 101. 2 | 21216 | 5 | 10g. CI 1121 | USA | |
| BY FUNERAL | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 1 Never Married 2 Married 1 Ves 2 No If Yes, GIVE WAR OR DATES 1 Ves 2 No Specify: 1 Ves 2 No Specify: 1 Ves 2 No Specify: | | | | | | | | |
| | 15, DECEDENT'S EDUC | ATION | 16a. DECEDENT'S | USUAL OCCUPATION | | 16b. KIND OF BUS | SINESS/INDU | Black | |
| COMPLETED | (Specify only highest grade of Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT us | | | D 11 | . 1 1. | G | |
| OMF | 17. FATHER'S NAME (First, Middle, Last) | | Ма | intenand | | ME (First, Middle, Malden | | em Steel | |
| BEC | William Ames | | | | Agnes | Coston | | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | | | | | loute Number, City or Tow | | | |
| | Agnes Sears 20a. METHOD OF DISPOSITION | 200 | | N. Grant | | | | MD 21229 | |
| | N XBurial 2 ☐ Cremetion 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify) | val from State cem | etery, grematory or o | | | 1 | | . Co, MD | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | | | | ADDRESS OF FAC | | | | |
| | > SV € HOI | - July | | 108 | . Nor | th Ave. | Balt | o, MD 21201 | |
| and the same of th | 23. PART I. Enter the diseases, or construction in the construction resulting in death) | let only one cause on a | ech iine. | , | | | retory arre | Approximate interval Between Onset and Desth | |
| ERTIFICATION | Sequentially list conditions, if sny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST | DUE TO (OR AS A | CONSEQUENCE O | | cci de | nt | | - | |
| MEDICAL CE | PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PRODINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | | |
| | DID TOBACCO USE C | ONTRIBUTE TO | CAUSE OF | | | A | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: 1 Inpatient 2 ER/Outp | etlent 2 Dogs | QTHER: | E OF DEATH (Che | 1 2 2 2 2 2 2 2 2 | | | |
| , H | 27. MANNER OF DEATH | 28a, DATE OF INJURY | 28b. TIM | E OF 28c, INJUR | Y AT | 6 Other (Specify) 26d. DESCRIBE HOW I | NJURY OCCL | PRED | |
| BY F | 1 Natural 5 Pending Investigation | (Month, Day, Year) | | M 1 YES | 37 3 2 NO | | | | |
| 8 | 3 Sutcide 6 Could not be 4 Homicide determined | 26a. PLACE OF INJURY building, etc. (Spec | — At home, farm, | street, factory, office | | 261. LOCATION (Street of City or Town, State) | and Number o | r Rural Route Number, | |
| COMPLET | and / | SIAN: To the best of my knowless on the best of examination | | | | | | d. cause(s) and menner ea stated. | |
| TO BE | 29b. SIGNATURE AND TITLE OF CERTIFIER Tyotin Packl 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | cahl | 2000 | D321 | S8 | 29d. DATE | SIGNED (Month, Day, Year) | |
| | Jyotin Pacik 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGN | | | reet, Sh | ite 407, | Baltin | nose MD 21201 | |
| 1 1 | | | | | | | | | |

DHMH-16 Rev 1/89

10

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| 51 | | 7 tr m:1. | - 11 0 7 | | 0 / | | | | | 9 | 4 | 2638 | 2 |
|------------|--|--|------------------------------|--|------------|-------------|-------------------------------------|-------------------------|--------------|-------------|------------|------------------------|---------------|
| | Item#9a Per F FOR T- STATE REGISTRAR | STATE OF MA | RYLAND / | DEPART | TMEN | T OF H | IEALTH AND | MENTAL | | IE | 7 (| 2000, | 4 11 |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | :HIIFI | CATI | E UF | DEATH | 2. DATE OF MONTH | REG. NO | AY | YEAR | 3. TIME OF DEA | ТН |
| | EARL 4. SOCIAL SECURITY NUMBER | C. | | | | ADA | | AUG | | 0 | 94 | 5:13 | P.M |
| | | 5. SEX 6. | AGE (In yrs. las | | MONTHS | DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF (Month, I | Day, Ybar) | | Count | | oreign |
| | 140-10-6408 | | 72 | 7,004,00 | nh CITY | TOWN! | D LOCATION OF D | 7-7-1 | 922 | Latinai | | RIDA | |
| DIRECTOR | 98. FACILITY NAME 1906 W. Fayette Street 99. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY 90. COUNTY OF DEATH BALTIMORE CITY | | | | | | | | | | | | |
| EC | 10a. STATE 10b. COUNTY | r | | 10c. CITY | , TOWN | OR LOCAT | TION | | | | | 10d. INSIDE CITY | Υ |
| PIG | MARYLAND | | | | BAI | LTIM | ORE CITY | | | | | LIMITS? | NO |
| | 10e. STREET AND NUMBER | | | | 2111 | | . ZIP CODE | | | 10g. CIT | IZEN OF V | VHAT COUNTRY? | |
| EB | 1906 W. FAYETTE ST | TREET | | | | | 21223 | | | | USA. | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT E | VER IN U.S. AR | MED | 13. | WAS DEC | ENDENT OF HISPAN | NIC ORIGIN? | Specify Yes | or No- | | E — American Indi | len, |
| BY F | t Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 X | OR DATES | Ю | | | ecify Cuben, Maxica 2 NO Specify | | en, etc.) | | Speci | | |
| | | | ARMY | | | | | | | | BLA | ACK | |
| 핕 | 15. DECEDENT'S EDUC (Specify only highest grade | completed) | (G | CEDENT'S L ive kind of we Do NOT use | ork done | durina mo | ON ist of working | 16b, K | IND OF BU | SINESS/INI | DUSTRY | | |
| = | Elementery/Secondary (0-12) UNKNOWN | College (t-4 or 5+) | | | | | | 000 | I C M D I I | am to | 7 (70) | 472 4 2777 | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | ONTRA | CIOI | K | 18. MOTHER'S NA | | | | N COL | IPANY | |
| U U | EARL C. ADAMS | S | | | | | ESTE | | ule, Malden | Sumame) | BALI | OLIT N | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | <u> </u> | 191 | . MAILING | ADDRES | S (Street a | nd Number or Rural i | | City or Tow | n Stata Zir | | DMIN | |
| 일 | HATTIE M. BATES | | | | | | TE STREE | | | | | 11223 | |
| | 20a. METHOD OF DISPOSITION | | 20b. PLACE | | | | | DATE | 7 | CATION — | | | |
| | 1 1 Sq Burial 2 ☐ Cremetion 3 ☐ Remo | oval from Stata | cemetery cre | matory or oth | ner niecel | | EMETERY | 1 | | | • | S, MARYL | AND |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | | | | D ADDRESS OF FA | | 1 0.1.1 | 1100 1 | | , ILIKI | 21110 |
| | Kland | 1.15 | n |) | | 1913 | PH H. BR | ORE ST. | . BATT | TMORE | MD | ME, P.A. 21223 | |
| | 23. PART i. Enter the diseeses, or c shock, or heart feliure. | complications that co List only one cause | eused the de on eech line | eth. Do no | ot enter | the mo | de of dying, suc | h ss csrdle | c or reapi | iratory sn | rest, | Approxim Interval B | |
| | iMMEDIATE CAUSE (Fine) disease or condition | | | | | | | | | | | Onset sn | |
| | resulting in desth) | Hyperten | SIVE | Arte | rio | scl | erotic | Card | iova | scul | lar | Diseas | e |
| _ | | DOE TO (OF | AS A CUNSE | DUENCE OF |): | | | | | | | | |
| TIFICATION | Sequentielly list conditions, | b DUE TO (OF | R AS A CONSEC | UENCE OF |): | - | . – | | | | | | |
| Ä | if sny, lesding to immediate csuse. Enter UNDERLYING | | | | | | | | | | | į | |
| 트 | CAUSE (Disease or injury that initieted events | DUE TO (OF | R AS A CONSEC | UENCE OF) |): | | | | | | | | |
| ERT | resulting in death) LAST | d | | | | | | | | | | | |
| 0 | | | | date t | | | | | | | | | |
| MEDICAL | PART II. Other significent condition | s contributing to de | eth but not r | eculting in | 1 the ur | nderiyinç | g csuse given in | Part i. 2 | PERFOR | | 24b. | WERE AUTOPSY F | TO |
| | | | | | | | | — ¹ | YES 2 | X NO | | OF DEATH? | LAUSE |
| | DID TODA CCO LICE COLUT | | | | | | | | INQU | IRY | | t 🗌 YES 2 🗍 | NO |
| SICIAN: | DID TOBACCO USE CONTI | CIBUTE TO CAUS | | E OF DEATH | | | UNCERTAIN | <u>и П Г</u> | | | | | |
| S | EXAMINER? | HOSPITAL: | | т. | OTHE | B. | v | | | | | | $\overline{}$ |
| PHYS | 27. MANNER OF DEATH | 1 Inpetient 2 EF | | 26b. TIME | | 28c. INJ | e 5 Aneldence | 6 Other (5 | | N.IURY OC | CUBED | | |
| | t Netural 5 Pending | (Month, Day, | | INJU | M M | WO | RK? (ES 2 NO | Eva. DE Vo. | | | OUNED | | |
| D BY | 2 Accident Investigation 3 Suicide 6 Could not be | 26a. PLACE DF IN | NJURY — At ho | me, term, at | reet, fec | | | 261. LOCATI | ON (Street a | and Number | or Rural F | Route Number, | - |
| 1 11 | 4 Homicide detarmined | building, atc. | . (Specify) | | | | | City or | lown, State) | | | | |
| iii ii | 29a. CERTIFIER 1 CERTIFYING PHYSIC | CIAN: To the best of my | knowledge de | eth occurred | d at the t | lmo dete | and place, and due | to the same | (a) and ma | | | | |
| COMPL | (Check only one) 2 X MEDICAL EXAMINE | | | | | | | | | | |) and manner as a | stated. |
| | 20). SIGNATURE AND TITLE OF CERTIFIER | | 1 | 1 | | | | | _ ,va, att | | | | |
| 띪 | 12 The Control of the | NUR. | X 1 | 1 | | | 29c. LICENSE NUN | | | | | (Month, Day, Year) | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | O COMPLETED CAUSE | DEATH (ITE | 1 27) (Bare) | Print) | | 0.C. | M.E. | | P | UG | 31,199 | 4 |

Mario F

31. DATE FILED (Month, Day, Year)
SEP 0 9 1994

Golle

M.D.

32. REGISTRAR'S SONATURE

DHMH-16 Rev t/89

111 Penn Street, Baltimore, Maryland

A Marie 19 1

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

3. TIME OF DEATH

2

BIRTHPLACE (State or Foreign

MARYLAND

10d. INSIDE CITY

14. RACE — American Indian, Black, White, atc.

1 TYES 2 NO

WHITE

21208

MD 21215

Approximate

Interval Between

Onset and Death

9c. COUNTY OF DEATH

AT HOME

BALTOE

10g. CITIZEN OF WHAT COUNTRY?

USA

401

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

2

31. DATE FILED (Month, Day, Year)

SEP

9 1994

1. DECEDENT'S NAME (First, Middle, Last, 2. DATE OF DEATH +R MON 4. SOCIAL SECURITY NUMBER In vrs last birthday IF UNDER 1 YEAR IF LINDER 24 HRS 7. DATE OF BIRTH HOURS 1 M 2 P Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH PITAL HO(DIRECTOR ALTO CITY MP RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION BALTIMORE MARYLAND BALTIMORE permit. FUNERAL 10s. STREET AND NUMBER 101. ZIP CODE detached for use as the burial-transit 21208 33 STONEHENGE CIRCLE, APT. 7 ours after death. Page 6 may be retained by the hospital or attending physician. I by the funeral director, page 5 should be detached for use as the burial-tran 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Merried 2 X M IF YES, GIVE WAR OR DATES B 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) 12 HOUSEWIFE once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ JOSEPH HONIGSBERG BESSIE BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 33 STONEHENGE CIRCLE, APT. 7 BALTIMORE, MD MR. PHILIP BECKER pe 20e. METHOD OF DISPOSITION

1 X Youriel 2 Cremetion 3 Removal from State METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must BETH EL MEMORIAL PARK 9-8-94 RANDALLSTOWN, MD Donation 5 Other (Specify) examiner TURE OF FUNERAL SERVICE LICENSE 22. NAME AND APORESS OF EACHTY & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, removal medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 6 filled IMMEDIATE CAUSE (Final cremation. other traumatic event, the disease of condition completely resulting in death) executed wit DUE TO (OR AS A CONSEQUENCE OF) and com CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) the attending physician a Mental Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING the death certificate be CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL signed by t HOSPITAL OR ATTENDING PHYSICIAN: The law requires that any Health a Shows Deen of ! DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES PHYSICIAN: has be Dept. 23 NO [25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item certificate h HOSPITAL **EXAMINER?** OTHER 1 YES 2 10 npatient 2 - ER/Outpatient 3 -DOA 5 🗌 Residence 0 the 27. MANNER OF DEATH 28a. DATE OF INJURY 28c. INJURY AT WORK? this c marked, 28b. TIME OF 1 Tatural 5 Pending Investigation 1 YES 2 NO DIRECTOR: After the hours after death value 1st mark BY 2 Accident 28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Suicida 8 Could not be PLETED 4 Homicide CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FIED WITHIN 72 h 2 MEDICAL EXAMINER: On the beels 29c. LICENSE NUMBER

E AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DIATH ITEM 27) (Typo, Print)
LEVINARD LICI+12- MT

mb

24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AMILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 ELINO OF DEATH? 1 TES 2 NO 28d, DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (M) a 00 OUR DHMH-16 Rev 1/89 invest fu

. .

| BALTIMORE, MARYLAND 21215-0020 | ours after death. Page 6 may be retained by the hospital or attending physician. | LET TO EAfter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should have a continued by the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | nedical examiner must be notified at once. | |
|--|---|---|---|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760. | OF AT NOTING PHYSICIAN: The law requires that the death certificate be executed with. Cours after death. Page 6 may be retained by the hospital or attending physician. | LEAR TO I. After this certificate has been signed by the attending physician and completely filled in by the f Name of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | lensed is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | |

TO THE HOSTO TO THE FUE Do filed with

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLAN | ID / DEPARTME | | | MENTAL | HYGIEN | E | | | |
|------------------|--|--|--|----------------------|------------------------------------|---------------|----------------------------------|----------------|-----------|-------------------------------|--------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | OF DEATH | | | 3. TIME OF DEATH | |
| | MILTON BA | RKSDALE | | | | SEPT | | .1994 | EAR | 04:06 | Δм |
| | 4. SOCIAL SECURITY NUMBER 5 | | LACE (State or Fore | | | | | | | | |
| | 218-62-9402 1 9a. FACILITY NAME (If not institution, give street | XM2 □ F 40 | | | HOURS MIN. | 06 | 20 | 54 1 | Mar | yland | |
| œ | 1 | | | | R LOCATION OF D | EATH | | 9c. COUNTY | OF DEA | ATH | |
| DIRECTOR | SINAI HOSPITAL | E.R. | | BALT | MORE | | | | | | |
| IRE | 10a. STATE 10b. COUNTY | | 10c. CITY, TOW | | 51 | a | | | 1 | IOd. INSIDE CITY | |
| | Maryland 100. STREET AND NUMBER | | | | imore | City | | December 1 | | YES 2 N | • |
| FUNERAL | 5235 KNXXXXXXXX | KWWK St. Cl | narles A | 100 | 2121 | 5 | | | JSA | IAT COUNTRY? | |
| S | | . WAS DECEDENT EVER IN U. | S. ARMED | 13. WAS DEC | ENDENT OF HISPA | NIC ORIGIN | ? (Specify Yes | | RACE - | - American Indian | |
| ВУ F | 1 Never Married 2 Married 3 Wildowed 4 Divorced | FORCES? (X) YES | | | city Cuban, Maxica 2 KNO Specif | | lican, etc.) | | Specify: | White, atc. | - 1 |
| | 16. DECEDENT'S EDUCAT | ION 14 | Sa. DECEDENT'S USUA | OCCUPATIO | A1 | 1 400 | KIND 05 BUS | SINESS/INDUS | - | Black | |
| ETE | (Specify only highest grade cor | npleted) College (1-4 or 5 +) | (Give kind of work do life. Do NOT use retire | one during mo: | | 160. | KIND OF BUS | SINESS/INDUS | IHY | | |
| AP. | 12 | | Con | nstru | ction | | Se1 | f-Em | olo | yed | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | AME (First, M | | | | | |
| BE | Milton Barksdal | e. Sr. | | | | | | Grie | | | |
| 2 | 19a INFORMANT'S NAME (Type/Print) Emma Grier | | 19b. MAILING ADDR | | ty Hei | | | | | MD 2120 | 7 |
| | 20a, METHOD OF DISPOSITION | 20b. Pl | ACE AND DATE OF DIS | POSITION (Na | ne of | | | CATION — City | | | - |
| | 1 NBurial 2 Cremation 3 Ramova 4 Donation 5 Other (Specify) | trom Symmetric Gai | ry, crematory or other pla | orest | | | | | | Maryland | |
| | 21. SIGNATURE OF FUNERAL SERVICE DICEN | SEE C | | | D ADDRESS OF FA | | TT a m a | | | | |
| | & ment of. | 1 Emg. In | / | 108 | y Fune W. NOr | th A | v. F | Balto | . M | D 21201 | ı |
| | 23. PART I. Enter the disesses, or comehock, or heart failure. Lis | plications that caused the | ne dsath. Do not sn | itsr ths mo | ds of dying, suc | h ss csrd | lsc or respli | retory srrest | 7 | Approximate | |
| | IMMEDIATE CAUSE (Finsl disesse or condition | | | 4. | 1 -0 | - 10 | 1 | 1 | ~ , | | |
| | resulting in desth) s | Hyperten & | and AM | lleros | Clepatic | (m | dio va | Waler 1 | 10 | sense | |
| 2 | | July 10 (ON AS A CO | MSEODENCE OF J. | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, isading to immediate | DUE TO (OR AS A CO | ONSEQUENCE OF): | | | | | | | | |
| S | Cause. Enter UNDERLYING CAUSE (Disease or Injury | | | | | | | | | | |
| | that initiated events resulting in daeth) LAST | DUE TO (OR AS A CO | INSEQUENCE OF): | | | | | | | | |
| E | d | | | | | | | | | <u> </u> | |
| ¥ | PART II. Other significant conditions of | ontributing to death but | not resulting in the | underlying | csuse given in | Part I. | 24a. WAS AN PERFOR | | | VERE AUTOPSY FIND | |
| ă | | | | | | | 1 YES 2 | NO | | OMPLETION OF CAL OF DEATH? | ISE |
| W | DID TOBACCO USE CONTRIB | LITE TO CALISE OF | DEATH VEC | I NO E | UNCERTAI | | inspe | clem | 1 | YES 2 NO | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | PLACE OF DEATH (Che | | UNCERTAI | МП | | | | | - |
| SIC | | OSPITAL: | | IER: Nursing Home | 5 - Rasidenca | 8 🗆 Other | (Specify) | | | | |
| PHYSICIAN: MEDIC | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJU | JRY AT | | | JURY OCCUR | ED | | \neg |
| ВУ | 2 Accident 5 Pending Investigation | | M | 1 | ES 2 NO | | | | | | |
| | 3 Suictde 8 Could not be 4 Homicide determined | 28a. PLACE OF INJURY — building, atc. (Specify) | At home, term, street, | factory, office | | | TION (Street a r Town, State) | nd Number or i | Rurel Rou | ite Number, | |
| E | 29s. CERTIFIER | | | | | | | | | | - |
| COMPLETED | (Check only | N: To the beat of my knowleds On the basis of examination ar | | | | | | | augalet - | and manner to state | |
| | | | | | | | | | | | ea. |
| H | Theod 71 | · Ki | | | 29c. LICENSE NUI | | | | | fonth, Day, Year) | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO C | OMPLETED CAUSE OF SEATH | (ITEM 27) (Type, Print) | | OCI | ME. | | SEF | т.(| 06,1994 | |
| | THEODORE | M. King 11 | | Stree | t, Bal | timo | re, M | arvla | and | 21201 | |
| | SEP 0 9 1994 | 32. REGISTRAR'S SIGNATU | IRE | | | | | | | | |
| | OLI U JIJJT | his Dandom Ran | nacc. | | | | | | | DHMH-18 R | 1 (22 |

| FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I | MENTAL HYGIENE REG. NO. |
|--|--|----------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH |
| Mary J. Brittian | | 9/ 4/ |

| | | 1. DECEDENT'S NAME (First | t, Middle, Last) | | | | | | | | 2, DATE OF DE | ATH | YEAR | 3. TIME OF DEATH | |
|--|--|--|-------------------------|------------------------------|-------------------|-------------------------------|-------------|------------|----------------------|--------------------------|--|----------------------------|-----------------|---|--|
| | | Mary J. Br | | | | | | | 4/ 1 | 22:00 M | | | | | |
| _ | | 4. SOCIAL SECURITY NUM | | 5. SEX | 6. AGE (In y | rs. last birthday | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF BI | RTN | | HPLACE (State or Foreign | |
| | | 214-01-262 |)3 | 1 🗆 M 2 🔯 F | 8: | Z YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, Day, 07/2 | | Count | y) cyland | |
| should | | 9a. FACILITY NAME (If not if | | treet and number) | | | 9b. CIT | . TOWN | OR LOCATI | ON OF DE | | | OUNTY OF E | 4 | |
| 2, 3 sh | DIRECTOR | St. Agnes Hospital Baltimore | | | | | | | | | | | | | |
| <u>~</u> " | [[| 10a, STATE | 10b. COUNTY | | | 100 0 | TY, TOWN | 201004 | TION | | | | | | |
| Pages | E | MD | Balti | | | | | | TION | | | | | 10d. INSIDE CITY LIMITS? | |
| permit. | | 10e, STREET AND NUMBER | | Arbut | _ | _ | | | | | 1 TYES 2 X NO | | | | |
| | FUNERAL | | | | | | | | H. ZIP COD | | | 100 | | WHAT COUNTRY? | |
| 020 physician. burial-transit | | 5527 Link | Avenue | | | | | 1 | 21227 | | | | S.A. | • | |
| 020 physician burial-tra | 5 | 11. MARITAL STATUS 1 Never Married 2 | Married | 12. WAS DECEDEN FORCES? 1 | T EVER IN U. | S. ARMED | 13. | WAS DE | CENDENT (| OF NISPAN | IIC ORIGIN? (Spi n, Puarto Rican, | elfy Yes or No- | 14, RAC Blac | E — American Indian, ik, White, atc. | |
| 0 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 | F YES, GIVE WAR OR DATES 1 ☐ YES 2 ▼ NO Specify: Specify: | | | | | | | | | | | | | | |
| 21215-0020 If or attending physic for use as the burial | | 15 DEC | EDENT'S EDU | CATION | 140 | - DECEDENT | 1 | 001017 | | | T | | 1 | white | |
| or affi | | (Specify on | ly highest grade | completed) | | (Give kind of life, Do NOT | work done | during m | ion ost of workii | ng | 16b. KIND | OF BUSINESS/I | NDUSTRY | | |
| | 2 | Elementary/Secondary (| 0-12) | College (1-4 or 5 | +) | | , | _ | | | | | | | |
| ANI the hosy detache | COMPLETED | 10 17. FATHER'S NAME (First, N | fictella (ant) | | | Seam | stres | S | | | | rment | | | |
| by the hospital be detached for at once. | | | , | 1 | | | | | | | A | Malden Surname |) | | |
| Ed to | BE | Charles W. | | neimer | | | | | | | Smith | | | | |
| MARYLAND 2- retained by the hospital o 5 should be detached for notified at once. | 2 | | . , | | | | | | | | | y or Town, State, | | | |
| m 2 0 2 | Charles Brittian 97 Weetbriar | | | | | | | | _ | 1 | | Delawar | | | |
| MOR metor, p | | 20b. PLACE AND DATE OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION Name of cemetery, crematory or other place) 20c. LOCATION — City or To | | | | | | | | | | | | | |
| Page 6: al directo | | 21. SIGNATURE OF TURBON | | er. | | idon P | ark (| eme | tery | | 9/7 | Baltim | ore, | Maryland | |
| ALTIMOR death. Page 6 m e funeral director, i. | | y month of lough | Lacked | AEMSEE | | | 22. | NAME A | ND ADDRE | SS OF FAC | Ambrose Funeral Home, Inc. Spring Road, Arbutus, MD 21227 | | | | |
| 2 . s = P | | Taul | " Ho | agam | | | 13 | 28 | Sulph | ur S | Spring 1 | Road, A | rbuti | as, MD 21227 | |
| 日本日本 | | 23. PART I. Enter the d | leedles, or o | omplications the | et ceused th | e deeth. Do | not enter | the mo | ode of dy | ing, such | h as cerdiec o | r respiratory s | errest, | Approximate | |
| | | immediate cause (Fig. | eart failure, | List only one ceu | use on each | ilne. | 1 | - 21 | | | | | | Interval Between Onset and Death | |
| 50, within within the cremation, rent, the | 1 | disease or condition | → | 50 | -4: | - 2 5 | he | K | | | | | | 244. | |
| s760, nted within completely fills completely fills ial, cremation, | H | resulting in death) | | OUE TO | | NSEQUENCE | | | | | | | | 100 | |
| 68760 ecuted with and comple burial, crer atic even | z | | | Ph | Quu. | ucu | × . | | | | | | | 24 64 | |
| | 은 | Sequentially list condit if any, leading to imme | | QUE TO | (OR AS A CO | NSEQUENCE (| OF): | | .0 | T | > 1 | 1 | | | |
| BOX cate be es thysician e prior to | S | cause, Enter UNDERLY CAUSE (Disease or Inju | | e Gas | 5000 | 144 | 527 | 14 | | 15 | 3/666 | 415 | | 2 Yhi | |
| , P.O. B eath certificate attending physintal Hygiene prints y, or other to | CERTIFICATION | that initiated events | | DUE TO | (OP AS A CO | NSEQUENCE | OF): | 1 | 1 | | | | | -11 | |
| P. ath of tending Hy | H | resulting in deeth) LAS | " L | d | 100 | 1a/ | | ta | 110 | لک ع | } | 0 | | Stre | |
| ECORDS, F quires that the death n signed by the atten f Health and Mental nows any injury, o | - 11 | PART il. Other significe | ent condition | s contributing to | death but | not resulting | In the w | darlula | C COURS | aluen in | Dort I Total | WAS AN AUTOPS | v 0.44 | WERE AUTODOU FRIENDS | |
| ECORDS, quires that the de n signed by the at f Health and Ment ows any injury | MEDICAL | | Die | - het | 29 | not recounting | | derrym | ig couse i | g19011 111 . | 240. | PERFORMED? | 240 | MAILABLE PRIOR TO | |
| LECO puires that signed Health a | | | 12/0 | ~ " | | | | | | | 10 | YES 2 NO | | OMPLETION OF CAUSE DF DEATH? | |
| RECC requires seen signe of Health | - 1 | DID TOBACCO |) LISE C | ONTDIBLITE | TO C | LICE OF | DEAT | uv | /EC [] | NO | - | | | 1 YES 2 NO | |
| Z3 tent | AN | | | CONTRIBUTE | . 10 0 | AUSE OF | DEA | | | NO | | | | | |
| VISION OF VITAL RE ATTENDING PHYSICIAN. The taw requestions: After this certificate has been a after death with the State Dept. of 128 is marked, or litem 23 sho | SICIAN: | 25, WAS CASE REFERRED T EXAMINER? | O MEDICAL | HOSPIML: | | | OTHE | | LACE OF D | EATH (Che | eck only one) | | | | |
| CIAN CIAN the S | 1×S | 1 NES 2 NO | | 1 Latipatient 2. | | | 4 🗆 Nur | sing Non | | sidence | 6 Other (Spec | | | | |
| A His c | PHY | 27. MANNER OF DEATH 1 Natural 5 | Pending | 28s. DATE OF | No. No. | 28b. TH | JURY | AAC | JURY AT ORK? | | 28d. DESCRIBE | HOW INJURY O | CCUREO | | |
| ION OF NDING PHYS I: After this or r death with is marked, | À | 2 Accident | Investigation | 20, 20, 405.0 | No. in in initial | 1 | | 17 | | NO | 14 | 2 | | | |
| TSIC TTEND TOR: / | | 3 Suicide 8 4 Homicide | Could not be datermined | building, | atc. (Specify) | At home, farm, | straet, fac | ory, offic | ce | | 28f. LOCATION Gity or Tow | (Street and Number, State) | per or Rural i | Route Number, | |
| | | 20. CERTIFIER | Henry | | - | 10 | 1 | | | | | 10/4 | | | |
| 29s. CERTIFIER (Check only one) 29s. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | |
| TO THE HOSPITAL TO THE FUNERAL be filed within 72 i | Check only one) Compared at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Compared at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Compared at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Compared at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | s) and manner as stated. | | | | | |
| # # FU W W | BEC | 29b. SIGNATURE AND TITLE | or Centrica | 7 | | | | | 29c. LICI | NSE NUM | IBER / |) 29d. D/ | ATE SIGNED | (Month, Day, Year) | |
| TO THE TO THE De filed v | - 11 | 1/ | // | | | | | | 10 | 295 | , vei | • | 9/ | 4/94 | |
| | 2 | 30. NAME AND ADDRESS OF | F PERSON WH | O COMPLETED CAU | SE OF DEATH | (ITEM 27) (Typ) | e, Print) | 1 | | ~ | | | | | |
| | | Jeffier | Sur | 1607 | 900 | Ca-1 | ch | 4. | J. 1 | Sa | 1tim | 4/2 | M | P | |
| | | 31. DATE FILES (100), Day. | å"100 A | 32. PEGISTRA | R'S SIGNATU | RE | | | | | | | | | |
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31. DATE FILED (MONTH), Dely, Your)
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| | | FOR 1 - STATE REGISTRAR | STATE OF MARYLAND / | | RTMENT OF H | | | E | | |
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | -AIII | ICATE OF | DEATH | REG. NO. | | | TIME OF DEATH |
| | | GARALdine | R. BANG | 15 | | | MONTH DEATH | 1 911 | EAR | 19:51 A. |
| | | 4. SOCIAL SECURITY NUMBER 5. | SEX 6. AGE (In yrs. les | t birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTIN | 7 /9 | BIRTNPLA | CE (State or Foreign |
| _ | | 817-22-82401 | 1 M 2 X F 74 | YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, Your) | 1 ^ | Country) | |
| pinous | | 9e. FACILITY HAME (If not institution, give street | and number) | | 96. CITY, TOWN O | R LOCATION OF DE | EATH - | 9c. COUNTY | | |
| 2.3 | O. | UNIVERSITY HOSPIT | PAL | | BALTI | MORE CIT | Y | | | |
| - : | DIRECTOR | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | 10c. CI1 | Y, TOWN OR LOCAT | ION | | | 100 | I. INSIDE CITY |
| t. Pages | 뜸 | MARYLAND | | | BALTI | MORE CIT | Y | | 1(| LIMITS? |
| E | AL A | 10e. STREET AND NUMBER | | | 101 | ZIP CODE | | 10g. CITIZEN | OF WHAT | COUNTRY? |
| ptlysician. burial-transit permit. | FUNERAL | 311 NORTH SCHROEDER | R STREET | | | 21223 | | USA. | 1 | |
| physician burial-tra | <u>E</u> | 11. MARITAL STATUS 12 1 Hever Married 2 Merried | . WAS DECEDENT EVER IN U.S. AR FORCES? 1 YES 2 X N | | 13. WAS DEC | ENDENT OF HISPAN | HC ORIGIN? (Specify Yes n, Puerto Rican, etc.) | or No- 14. | RACE - / | American Indian, hite, efc. |
| | B | 3 XWidowed 4 Divorced | IF YES, GIVE WAR OR DATES | | 1 TYES | 2 X NO Specify | <i>(</i> : | Ι, | Specify: | |
| S end S | 유 | 15. DECEDENT'S EDUCATI | | CEDENT'S | USUAL OCCUPATIO | PH | 16b. KIND OF BUS | | BLACK | |
| 5 5 | ETEI | (Specify only highest grade com Elementary/Secondary (0-12) C | | | work done during mos se retired.) | st of working | | | | |
| 3 g c | COMPL | 11th GRADE | | PAC | KER | | CANNER | .Y_ | | |
| 4 8 8 E | 8 | 17. FATHER'S HAME (First, Middle, Last) | CKSON | | | | ME (First, Middle, Melden | | ITION. | |
| etained by should be officed at | H | ROBERT JA 190. INFORMANT'S NAME (Type/Print) | | | | MARY | | ASHING | | |
| 2 2 2 | 2 | PHYLLIS JONES | 7.0 | | | | Route Number, City or Tow. ALTIMORE, | | | 1017 |
| Z Sage | | 20e. METNOD OF DISPOSITION | 20b. PLACE | | OF DISPOSITION (No. | | | CATION — City | | |
| must | | Buriel 2 ☐ Cremetion 3 ☐ Removal Donation 5 ☐ Other (Specify) | cometary, are | | center place) | | 9-12-94 BAL | TIMORE | . MA | RYI.AND |
| death. Page 6 m funeral director. | | 21. SIGNATURE OF TUNERAL SERVICENS | | | 22. NAME AN | D ADDRESS OF FA | CILITY | | | |
| | | Marke | - U./A | 5 | | | WN JR. FUN MORE ST | | | |
| ours after d in by the or removal. | | 23. PART I. Enter the diseases, or com | plications that caused the de | ath. Do | not enter tha mo | da of dying, suci | h ss cardiac or respi | ratory arrest | UKE | Approximsta |
| Do or in | | IMMEDIATE CAUSE (Final | only Dna cause Dn aach lina | | | - | | | İ | Interval Batween Onset and Dasth |
| with pletely fille cremation. | | disesse or condition resulting in death) s | GAM NE | gA- | tive s | Septic | emiA | | | 3d |
| B 2 - 6 | | | DUE TO (OR AS A CONSEC | DUENCE O | F): | U | | | | |
| and and burn | ON | Sequentially list conditions, b. | DUE TO (OR AS A CONSEC | DUENCE O | FI- | | | | | |
| or cian | CATIO | if any, leading to immediate cause. Enter UNDERLYING | | 3021102 0 | . ,. | | | | j | |
| nding physiene progree | RTIFIC | CAUSE (Disease or injury that initiated eventa | DUE TO (OR AS A CONSEC | DUEHCE O | F): | | | | | |
| L 5 5 0 | E | resulting in desth) LAST | | | | | | | | |
| | L C | PART II. Other significant conditions of | ontributing to death but not r | eaulting | in the underlying | csuse given in | Part I. 24s. WAS AN | AUTOPSY | 24b. WE | RE AUTOPSY FINDINGS |
| The state of the s | MEDICAL | Heart Failuse | | | | | PERFOR | | COI | ILABLE PRIOR TO MPLETION OF CAUSE |
| St of the R | 핗 | Coronary Arte | ry Disease | 2 | | | | O.V. | | DEATH? YES 2 NO |
| . 2 dl 11 mm | | DID TOBACCO USE CO | NTRIBUTE TO CAUS | SE OF | DEATH Y | ES NO |) \Zi | | | |
| Mark Total | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | OSPITAL: | | | ACE OF DEATH (Ch | eck only one) | | | |
| 24.5 | YSI | 1 TYES 2 NO 1 | Inpatient 2 ER/Outpetient 3 | | | e 5 🗆 Reeldence | 8 Other (Specify) | | | |
| Si Li | РНҮ | 27. MAHHER OF DEATH 1 Natural 5 Pending | (Month, Day, Year) | 28b. TIR IH. | JURY WO | RK? | 28d, DEŞCRIBE NOW I | HJURY OCCUR | ED | |
| 9 4 1 | B | 2 Accident Investigation | 28e. PLACE OF IHJURY Af ho | me ferm | " ' ' ' | ES 2 NO | 281. LOCATION (Street of | and Number or | Quest Doub | Number |
| OR ATTENDI DIRECTOR: A hours after the | TED | 4 Homicide 8 Could not be | building, etc. (Specify) | , | and the state of t | | City or Town, Stete) | ING NUMBER OF | TOURS FROM | Wallion, |
| te hour pa | LET | 290. CERTIFIER 1 CERTIFYING PHYSICIAL | N: To the best of my knowledge, de | ath occur | red at the firms, date | and place, and due | to the cause(e) and mar | noer on eleted | | |
| # 25 F | OMPL | anat | on the basis of examination end/or i | | | | | | | d manner ee stated. |
| E HOSPE E FUNER d within RTANT: | ECC | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUM | | / | | orth, Day, Year) |
| TO THE HOSP! TO THE FUNEF De filed within | 00 | Mita aldor | M.D. | | | | V | D 91 | 5/9 | 4 |
| | 임 | 30. NAME AND ADDRESS OF PERSON WHO CO | OMPLETED CAUSE OF DEATH (ITE | M 27) (Type | , Print) | | | 1 | 1 | |

132. REGISTRAR'S SIGNATURE Street BAltimore, MD 21201

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South

| DIVISION OF VITAL RECORDS, F | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The Line inquires that the death | TO THE FUNERAL DIBERTIES After this certifician has been signed by the atter- te field within 72 | IMPORTANT: If nemyers, marked, or tem 23 shows any Injury, o |
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| | TO THE HO | TO THE FUN | IMPORTA |

| | FOR 1 - STATE | STATE OF MARY | LAND / | DEPAR | TMEN | T OF H | EALTH | AND I | MENTA | L HYGIEN | y L IE | 1 2 | 6387 | | |
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| | REGISTRAR | | | RTIF | | | | | | REG. NO | | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE | OF DEATH | MY | YEAR | 3. TIME OF DEATH | | |
| | STEVEN JARV | /IS BAR | NETTE | , SR | • | | | | 9 | | 0 | 94 | 7:0 | O Mi | |
| | 4. SOCIAL SECURITY NUMBER 5 | S. SEX 6. AG | E (In yrs. las | t birthday) | | R 1 YEAR | IF UNDER | | 7. DATE | OF BIRTH | | 6. BIRTI | IPLACE (State or Fore | eign | |
| | 212-58-2190 | X M 2 □ F 4 | 3 | YRS. | MONTHS | DAYS | HOURS | MIN. | | H 24,1 | 951 | RA | LTO., MD | | |
| | 9a. FACILITY NAME (if not institution, give stree | t and number) | _ | | 9b. CIT | Y, TOWN C | R LOCATI | | | 2792 | | JNTY OF D | | | |
| DIRECTOR | 1553 COLE STREET | | | | BA | LTIM | ORE | | | | | | | | |
| <u>iii</u> | 10a. STATE 10b. COUNTY | | | 10c. CIT | Y, TOWN | OR LOCAT | ION | | | | | | 10d. INSIDE CITY | _ | |
| 1 2 | MARYLAND | | | | BAT. | TIMO | RE | | | | | | LIMITS? | NO. | |
| 甘 | 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT C | | | | | | | | | | | | | | |
| FUNERAL | 1553 COLE STREET | | | | | | | | | | | | | | |
| I Z | | 2. WAS DECEDENT EVER | | | 13. | WAS DEC | | | | N? (Specify Ye | | | E — American Indian | | |
| BY FI | 1 Never Married 2 Married 3 Widowed 4 Divorced | S 2X N | 10 | | If yea, spe | cify Cuba 2 X NO | ın, Mexica | n, Puario | Rican, etc.) | . 0. 110— | Black | White, atc. | ١. | | |
| O. | 15. DECEDENT'S EDUCAT | | 16a. DE | CEDENT'S | USUAL C | CCUPATIO | N N | | 168 | . KIND OF BU | SINESS/IN | | | | |
| E | (Specify only highest grade cor | mpleted) College (1-4 or 5 +) | (G/ | ve kind of a Do NOT us | work done | during mo | st of working | ng | - | | 01112001111 | 5551111 | | | |
| COMPLETED | 10TH GRADE | College (1-4 or 5 +) | WAR | EHOU | SEMA | N | | | | MONTGO | MERY | WAR | DS | | |
| S G | 17. FATHER'S NAME (First, Middle, Lest) | | 1,1,2,2,1 | | | | 16 MOTI | HED'S NA | _ | Middle, Maiden | | | | | |
| Ö | HENRY BARNETTE | | | | | | | ENA | | | Surname) | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 400 | | 400000 | 0.40 | | | | | | | | | |
| TO BE CON | HENRY G. BARNETTE | | | | | | | | | MORE, | | | 223 | | |
| 9 | 20a. METHOD OF DISPOSITION | | Ob. PLACE A | | | | | | DAT | | CATION - | | | | |
| E | 1 Burial 2 X Cremation 3 Remova 4 Donation 5 Other (Specify) | of from State | ametery, crei | metory or o | ther plece. | EMAT | ORY | | 9/9 | | TIMO | | wn, Stata | | |
| CXATHILLE | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE—BALTIMORE, MD. 21229 | | | | | | | | | | | | | | |
| a de la composição | 23. PART / Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | | | | | |
| E | shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | |
| E | IMMEDIATE CAUSE (Final disease or condition | Carcinoma - Floor of month | | | | | | | | | Onset and | Destil | | | |
| EH, | resulting in death) a | DUE TO (OR AS | | UENCE O | 7 t t | 207 |) - | 744 | 7 | _ | | | 172 | | |
| | | | | | , | | / | | | | | | İ | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS | A CONSEC | DUENCE O | F): | | | | | | | | | | |
| 밀 | CAUSE (Disease or injury that initiated events | DUE TO (OR AS | A CONSEC | UENCE OF | F): | | | - | | | | | | | |
| E | resulting in death) LAST | | | | | | | | | | | | Ì | | |
| C | d | | | | | | | | | | | | - | | |
| 201 | PART ii. Other significant conditions of | contributing to death | but not re | eaulting | in the u | nderlying | cause (| given in | Part i. | 24a. WAS AN | | 24b | WERE AUTOPSY FINE | | |
| MEDICAL | | | | | | | | | | PERFO | 1 | | AMAILABLE PRIOR TO COMPLETION OF CA | | |
| 2 III | | | | | | | | | | | 100 | | OF DEATH? | | |
| 2 | DID TOBACCO USE CONTRIB | BUTE TO CAUSE | OF DEA | TH YE | SX | NO 🗆 | LINC | ERTAIN | v П | | | | I TES 2 NC | , | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | 7012 10 0/1002 | | E OF DEAT | $\overline{}$ | | 0110 | LKIAII | 1 | | | | | | |
| Sic | | OSPITAL: | | | OTHE | R: | .V. | 300035-00 | I E I | | | | | | |
| - X | 27. MANNER OF DEATH | 28e. DATE OF INJUR | _ | 28b. TIM | _ | 28c. INJ | \rightarrow | aldenca | _ | or (Specify) | ALHIEV OC | CLIDED | | | |
| d | 1 Natural 5 Pending | (Month, Day, Year | | | URY | WO | RK? | NO | 200. DE | SCHIBE HOW | INJURY OC | CORED | | | |
| 16 | 2 Accident Investigation 3 Suicide a Could and by | 28e. PLACE OF INJU | BY — At hor | me ferm s | street for | | | J 110 | 204 1 00 | ATION (Street | | 0 1 (| | | |
| | 3 Suicide S Could not be determined | building, atc. (S) | oecify) | ,, | , , , | , | | | City | or Town, State) |) | or nover r | nodie Nambei, | | |
| | 29a. CERTIFIER CERTIFYING PHYSICIA | N: To the best of my kno | wlades de | eth occurr | ed at the | Ilma das- | and class | and 4: | to the ex- | unate) c=d - | 25 25/07 | | | | |
| Σ | | On the basis of examinat | | | | | | | | | | | and manage | tod | |
| COM | | 1 | | | ., my | | | | | and prece, ar | | | | ied. | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | 1-6-1 | 111 | | | | | ENSE NUM | | | 29d. DA | E SIGNED | (Month, Day Year) | | |
| 0 | 30 NAME AND ADDRESS OF PERSON WHO C | uya 1 | NO | | | | 00 | 243 | 36 | | | 7/6/ | 194 | | |

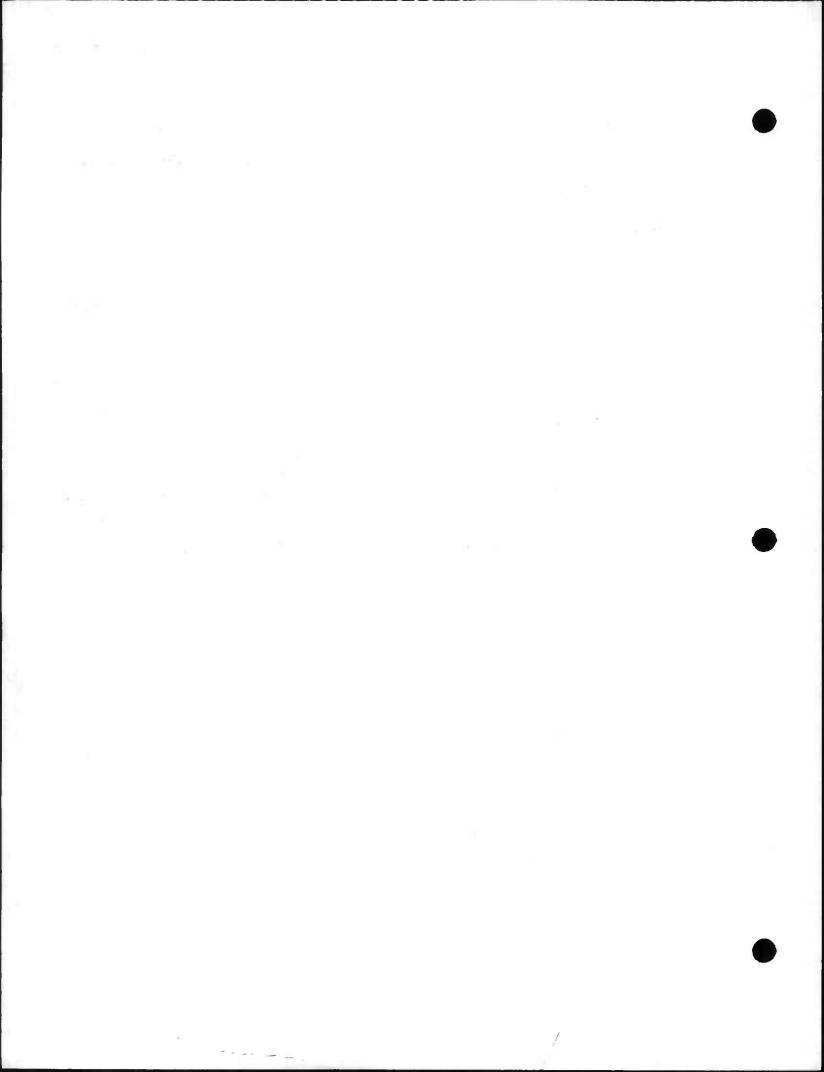
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

lates

SEP 0 9 1994

Hospital



| 1 | • | FOR STATE REGISTR | AR |
|---|------|-------------------------|----|
| | 1. D | ECEDENT'S | NA |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First, Middle ANNA | J. Ba | SLOVAR | 104 | TOATE | | DEA | ••• | 2. DATE OF DEAT | | 9 YEAR | TIME OF DEATH | | |
|---------------|--|---|---|--|---------------|----------------|----------|-----------|--|---|----------------------------------|--|--|--|
| | 4. SOCIAL SECURITY NUMBER 220-05-4245 | 5. 9EX 1 M 2 F | 6. AGE (In yrs. Ia | st birthday) YRS. | IF UNDER | 1 YEAR DAYS | IF UNDER | MIN. | 7. DATE OF BIRTI (Month, Day, Yo NOV . 29, | H or) | a. BIRTHPI Country) | ACE (State or Foreign | | |
| СТОВ | 99. FACILITY NAME (If not institution ST. MARTINS HO | ME | | | 9b. CITY, | | ONSV | | | 9c. COL | BALT | IMORE | | |
| DIRE | MARYLAND 10b. | BALTIMORE | | 10c. CIT | CA | | ISVIL | LE | | | | Od. INSIDE CITY LIMITS? YES 2 XX40 | | |
| FUNERAL | 100. STREET AND NUMBER 101. ZIP CODE 109. CITIZEN OF WHAT 101. ZIP CODE 102. CITIZEN OF WHAT 103. CITIZEN OF WHAT | | | | | | | | | | | | | |
| ВУ | 11. MARITAL STATUS 1 Never Merried 2 Merrie 3 Wildowed 4 Divorced | FORCES? | NT EVER IN U.S. AI I YES 2 H WAR OR DATES | | 1 | f yes, sp | | n, Maxica | NIC ORIGIN? (Specifier, Puerto Rican, etc.) fy: | | 14. RACE - Black, Specify: | - American Indian, White, stc. WHITE | | |
| PLETED | | r's EDUCATION st grade completed) College (1-4 or 5 | +) | DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | | | | | F BUSINESS/IN | | 2 | | |
| BE COMPL | 17. FATHER'S NAME (First, Middle, Lest) JOSEPH PANDA 18. MOTHER'S NAME (First, Middle, Melden Surname) ANNA GESL | | | | | | | | | | | | | |
| TO E | 194 INFORMANT'S NAME (Non-Print) | | | | | | | | | | | 21228 | | |
| | 20e. METHOD OF DISPOSITION 1 XBuriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE A DONATURE OF FUNERAL SERVICE LICENSEE A DONATURE OF FUNERAL SERVICE LICENSEE A DONATURE OF FUNERAL SERVICE LICENSEE A DONATURE OF FUNERAL HOME INC. 4 107 WILKENS AVENUE—BALTIMORE, MD. 21229 | | | | | | | | | | | | | |
| | 23. PARTY Enter the disease, or complications that caused the death. Do not anter the mode of dying, such se cerdisc or respiratory errest, abock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEDUENCE OF): | | | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b | | | | | | | | | | | | | |
| MEDICAL | PART II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. HIPOLIFICATION ANGUNA PERIORES NO 1 YES 2 NO | | | | | | | | 6 | VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO | | | | |
| SICIAN: | 25. WAS CASE REFERRED TO MED EXAMINER? | HOSPITAL: | | | ОТНБЕ | : | | | heck only one) | | | | | |
| BY PHYS | 1 VES 2 NO 27. MANNEB-OF DEATH 1 Neturel 5 Pendir 2 Accident Investi | 28a, DATE D (Month, | ER/Outpatient : FINJURY Day, Year) | 26b. T/8 | 4 Mura | 28c. INJ WC | | | 8 Other (Specify 28d. OESCRIBE H | | CCURED | | | |
| ETED E | 3 Suicide 8 Could 4 Homicide determ | not be building | OF INJURY — At he, etc. (Specify) | ome, tarm, | street, facto | ory, offic | • | | 281. LOCATION (S City or Town, | treet and Numbe State) | er or Rural Roo | ite Number, | | |
| COMPLE | one) 2 MEDICAL E | G PHYSICIAN: To the best of XAMINER: Dn the besis of | | | | | | | | | | and manner as stated. | | |
| TO BE | 29b. SIGNATURE AND TITLE OF CO | Il. Kuln | 5 | 4 | > | | 29c. LIC | ENSE NU | MBER 3-6 | 29d. DA | TE SIGNED /7 | Aonth, Day, Year) | | |
| - | 30. NAME AND ADDRESS OF PERS | 18, 716 | MALDE | M 27) (700 | APOR | 56 | WE | ,# | 205, B1 | 47/1 |) S (| ZZB | | |
| | 31. DATE ELLEP (Month, Day, Year) 1994 | Julia San | AR'S SIGNATURE | u | | | | | | B | | | | |

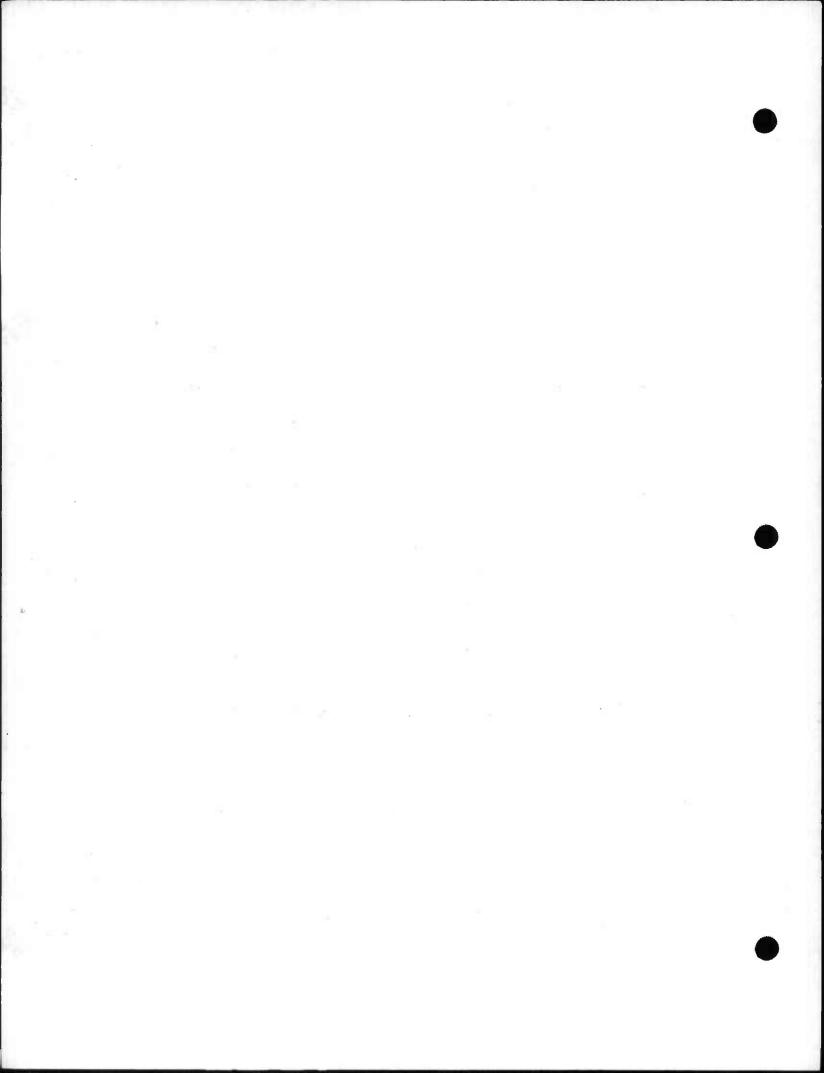
TO THE HOSPITAL OR ATTENDED. PHYSICIAN: The law requires that the death certificate be executed within and completely filled in by the retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 him. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First, | Miridia I anti | | | | IOAIL | <u>OI</u> | DLA | | HEG. NO | | _ | | |
|--------------|---|----------------------------|----------------------|--------------------|-----------------------------|---|--------------|--------------|---|--|---------------|-----------------------------|------------------------|--|
| 1 | | | | | | | | | | 2. DATE OF DEATH DON'TH D | AY | YEAR | 3. TIME OF DEATH | |
| | MARY | | RUTH | | | ALL | | | | 09 08 | | 94 | 1-00 A M | |
| | 4. SOCIAL SECURITY NUME | | 5. SEX | 6. AGE (In yrs. la | ist birthday) | IF UNDER 1 | YEAR DAYS | IF UNDER | | 7. DATE OF BIRTH (Month, Day, Year) | | 6. BIRTHP Country) | LACE (State or Foreign | |
| - 1 | 219-10-123 | 39 | 1 🗆 M 2 🖳 🗐 | 81 | YRS. | WONTERS | DAYS | HOURS | MIN. | 12-18-12 | , | | RYLAND | |
| | 9a. FACILITY NAME (If not in | stitution, give s | treet and number) | | | 9b. CITY, 1 | O MWO | R LOCATIO | ON OF DE | | 9c. COUNT | | | |
| <u>۳</u> | 3500 GREET | WALE ' | ROAD | | | | י דגם | TIMO | ממ | | | | | |
| DIRECTOR | RESIDENCE OF DEC | | T.CO. ID | | | | | IIIO | KE_ | | 1 | | | |
| W | 10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | | | | | | | | | | | 10d. INSIDE CITY LIMITS? | | |
| 5 | MARYLAND | | | | | BALT | TMO | RE | | | | | 1 X YES 2 NO | |
| 7 | 10e. STREET AND NUMBER | | | | | | 101. | ZIP CODE | E | | 10g. CITIZ | | AT COUNTRY? | |
| 18 | 3500 GREEN | WALE | ROAD | | | | | 2. | 1229 | | , | U.S | | |
| FUNERAL | 11. MARITAL STATUS | | 12. WAS DECEDEN | T EVER IN U.S. A | BMED | 13 W | AS DECI | | | IC ORIGIN? (Specify Yes | ar No. I r | | - American Indian, | |
| | 1 Never Married 2 | Married | | YES 2 X | | 11 | yes, spe | city Cuba | in, Maxicai | n, Puarto Rican, atc.) | 01110 | Black, | White, etc. | |
| BY | 3X Widowed 4 Divo | rced | 11 120, 0112 1 | WIN ON DAILS | | '' | 1E3 | ZX_XNO | Specify | : | | Specify | WHITE | |
| | | EDENT'S EDU | | 16a. D | ECEDENT'S | USUAL OCC | UPATIO | N | | 16b. KIND OF BU | SINESS/INDU | STRY | | |
| | Elementary/Secondary (0 | y highest grade | College (1-4 or 5 |) III | Bive kind of a Do NOT us | work done du se retired.) | ring mos | it of workin | ng | 50 m 1 m | | | | |
| | , , , , | , | 00.000 (1.4.0) 3 | ′ | ∞ | OK | | | | HIGH | SCHO | OL | | |
| once. | 17. FATHER'S NAME (First, M | liddle, Last) | | | | _ | | 18 MOTE | HER'S NA | ME (First, Middle, Maiden | Cumamat | | | |
| E U | ISAAC EDWAI | RD BOW | MAN | | | | | | 100000000000000000000000000000000000000 | ERINE KERN | | | | |
| B B | 19a. INFORMANT'S NAME (7 | vne/Print) | | 10 | DE MAIL INC | ADDRESS | Comment or | | | Toute Number, City or Tow | | | | |
| TO BE | MICHELE HOR | | (G-DAUGHT | | | | | | | | | | 1000 | |
| 9 | 20a, METHOD OF DISPOSIT | | G-DAUGIT | | | | | | AD BA | ALTIMORE M | _ | | | |
| must | 1 Burial 2 Crematio | n 3 🗆 Rem | oval from Stata | cemetery, or | ematory or o | OF DISPOSIT ther place) | ION (Nai | me of | - 00 | DATE 20c, LO | CATION — C | Ity or Tow | n, Stata | |
| - | Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) The Biographic of Chief Specify Community 22. NAME AND ADDRESS OF FACILITY 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | | | | |
| examiner | | | 5 | 26 | | 22. NAME AND ADDRESS OF FACILITY LEROY M & RUSSELL C WITZKE FUNERAL HOMES | | | | | | | | |
| exa | Kuge | * Lugueson i go | | | | | | | | | | | AL HOMES MARVIAND | |
| medical | 23. PART I. Enter the di | iseases, or | complications tha | t ceused the d | eath. Do r | not enter ti | he mod | de of dyi | ing, aucl | a a cerdiac or reap | ratory arre | at, | Approximate | |
| | shock, or heert feilure. List only one ceuse on each line. Interval Between Onset and Death | | | | | | | | | | | | | |
| | disease or condition | 101 | ~ | 1.1. | 1. | | | | | | | | | |
| event, | resulting in death) | 7. | DUE TO | OR AS A CONSE | OUENCE O | Car | iu | _ | | | | | 3 mosples | |
| | resulting in death) A Metastatic cance DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, If any leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| traumatic | Sequentially list conditi | | DUE TO | (OR AS A CONSE | QUENCE O | DEUX | u | | | | | | 1 mont | |
| TA: | if any, leading to imme- cause. Enter UNDERLYi | | | | | | | | | | | | | |
| P E | CAUSE (Disease or inju thet initiated events | ry | c. DUE TO | (OR AS A CONSE | QUENCE O | F): | | | | | | | + | |
| - C | reaulting in death) LAS | т . | | | | | | | | | | | | |
| - 111 | | | o | | | | | | | | | | | |
| Injury, | PART II. Other significe | ondition | s contributing to | deeth but not | resulting | in the und | erlying | ceuse g | given in | Part i. 24a. WAS AN PERFOR | | | WERE AUTOPSY FINDINGS | |
| EDICAL | | | | | | | | | | 1 YES 2 | | | COMPLETION OF CAUSE | |
| 2 | | | | | | | | | | _ | | | OF DEATH? | |
| sho | DID TOBACC | O USE | CONTRIBUT | E TO CAL | ISE OF | DEAT | H Y | ES [| 1 NC | | | | TES ZACIO | |
| tem 23 sl | 25. WAS CASE REFERRED TO | | | - 10 0/11 | | | | | | ck only one) | | | | |
| - 10 | EXAMINER? | | HOSPITAL: | F9/Outpetlant | 3 D DOA | OTHER: | | | | | | | | |
| PHY | 27. MANNER OF DEATH | | 28a. DATE OF | | 28b. TIM | | 8c. INJL | | sidence | S Other (Specify) 28d. DESCRIBE HOW I | N HIBY OCCI | IBED | | |
| 2 0 | | Pending | (Month, D | lay, Year) | | URY M | WOR | | NO. | zoo. Dzgombi, now i | WONI OCCU | MED | | |
| @ 16 | 2 Dudate | Investigation | 25a, PLACE O | F INJURY — At h | ome ferm | street factor | | | | 28I. LOCATION (Street | and Mumber of | a Ocean Co | to Muselan | |
| 28 E | | Could not be detarmined | building, | atc. (Specify) | | | ,, 011100 | | | City or Town, State) | ing Number o | r nurar no | ole Nambel, | |
| □ | 29a. CERTIFIER | | | | | - | | | | | | | | |
| AP I | (Check only | | | | | | | | | to the cause(a) and mai | | | | |
| MPORTANT: IF | 2 MEDI | CAL EXAMINE | R: On the beats of a | xamination and/or | Investigation | n, in my opi | nion, de | ath occur | red at the | time, deta and place, an | d due to the | cause(a) | and manner as stated. | |
| E C | 29b. SIGNATURE AND TITLE | OF CERTIFIE | R | | | | \Box | 29c. LICE | ENSE NUN | IBER | 29d. DATE | SIGNED (| Month, Day, Year) | |
| MPC B | K Jas | Lung | en n | 100. | | | | D | 140 | 9>- | 1 9 | 1/8/ | QV | |
| 을 | 30. NAME AND ADDRESS OF | PERSON WH | O COMPLETED CAU | SE OF DEATH (ITE | M 27) (Type | . Print) | _ | | | | | | | |
| | John A. Sino | rer. M | .D. 900 (| Caton Av | muc | Ral+ | _ | MD | 21229 | 0 | | | | |
| | 31. DATE FILED (Month, Day, | Year) | | R'S SIGNATURE | COUC. | Dall. | - | 14117 | 4.16. | 7 | | | | |
| | SEP 0 9 199 | 34 | Jani Danie | -0 | | | | | | | | | | |
| | | 0 | | m- year | | | | | | | | | OHMH-18 Rev 1/89 | |



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COMPLETED BY

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29b. SIGNATURE AND TITLE OF CERTIFIES

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Allon

SEP 0 9 1994

mayon

Johathon

Gun

Cohn

O. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MD

hospital or attending physician.

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| | leath. | funer | | хаші |
| | TO THE HOSPITAL OF ATTENDANCEMENTS TO Be law requires that the death certificate be executed within cours after death. Page 6 may be retained by the | TO THE FUNERAL DIRECTION AND THE CAPACICAL PROPERTY AND THE ADMINISTRATION OF THE FUNERAL DIRECTION AND THE FUNERAL DIRECT | be filed within 72 nouns after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at on- |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH WILLIAM COLEMAN JR. n/a M Sept 1994 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign SEPT8, 1962 217-88-9323 DAYS HOURS X X M 2 - F 31 MARYLAND YRS. 9a. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF DEATH 9b, CITY, TOWN OR LOCATION OF DEATH DIRECTOR 911 Cherryhill Road Baltimore N/A 10b. COUNTY 10a. STATE 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND n/a BALTIMORE YYES 2 NO 10e, STREET AND NUMBER FUNERAL 101. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? 911 CHERRYHILL ROAD 21225 UNITED STATES 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X 100 IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, Whita, atc. 1 Never Married 2 Married If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: Specify: BLACK 8 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION

One bland of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Spe econdary (0-12) College (1-4 or 5+) 12TH LABORER n/a 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname WILLIAM COLEMAN SR. MABEL KELLY BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MABEL COLEMAN 911 CHERRYHILL ROAD, BALTIMORE, MD#25 20x METHOD OF DISPOSITION
1 Burial 2 Cremation 3 Removal from State 20c. LOCATION — City or Town, Stata 20b. PLACE AND DATE OF DISPOSITION (Name of OATE cemetery, crematory of other place) CEMETERY LANSDOWNE, MD ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Karen MARCH FUNERAL HOME EAST 1101 E. NORTH AVE./BALTIMORE, MD 21202 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. intervai Betwe IMMEDIATE CAUSE (Final Onset and Death disease or condition Disseminated Myabaterial Disease (Suspect. M. avium culture 1 mosts reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): pending) Syndrume CERTIFICATION

mount delici eny Acquind 400-1. Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO OF DEATH? 1 - YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER 1 YES ZENO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ng Home 5 Residence 6 - Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED Natural 5 Pending м 1 YES 2 NO 2 Accident Investigation 28a. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suictde 6 Could not be determined 4 Homtelde 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basts of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

29c. LICENSE NUMBER

038224

5 Greene St Box 165 66 Baltmore 4 32. REGISTRAR'S SIGNATURE

29d. DATE StONEO (Month, Day, Year)

▶ 9/7/94

2/201

MO

DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - STATE REGISTRAR | STATE OF A | / MARYLAND Ci | | | | EALTH DEAT | | MENTA | L HYGIEN | E | | |
|---------------|--|------------------------|---------------------|--------------------------|-------------------|-------------|------------------------|-----------------|------------|----------------------------|-------------------------------------|---------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE | OF DEATH | · , | rEAR | 3. TIME OF DEATH |
| | Lloyd Carr | | | | | | | | | 9-4- | 94 | | 11 35 PM |
| | The second of the second of | 5. SEX 1 🖳 M 2 🗌 F | 6. AGE (In yrs. les | t birthday) YRS. | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. MIN. | (Mon | OF BIRTH | - 1 | Country | |
| | 9e. FACILITY NAME (If not institution, give street | | 74 | 9b. CITY, TOWN OR | | | IR I OCATIO | ON OF DE | _ | /15/192 | 920 KY 9c. COUNTY OF GEATH | | |
| 5 | Bayview Medical Ce | | | | | | more | | | | SC. COON | T OF O | -AIII |
| 5 | RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY | | | | L | | | | | | | | |
| DIRECTOR | Md 108. COUNTY | | | | y town o Balti | | | | | | | | 10d. INSIDE CITY LIMITS? |
| | 10e. STREET AND NUMBER | 10e. STREET AND NUMBER | | | | | | | | | 10a CITIZE | N OF W | 1 XYES 2 NO |
| FUNERAL | 3417 Leverton Aver | ue | | | | 11.00 | 212 | | | | | SA | |
| 5 | | AMED | | | | | | N? (Specify Yes | or No — 14 | I. RACE | — American Indian, , Whita, etc. | | |
| ВУ | 1 Never Married 2 Married 3 Widowed * 2 Norced | IF YES, GIVE W | YES 2 X | | | | 2 NO | | | Rican, etc.) | | Specif | y: |
| | 15. DECEDENT'S EDUCA | | 16a. DE | CEDENT'S | USUAL O | CCUPATIO | ON . | | 164 | . KIND OF BUS | INESS/INDUS | | white |
| COMPLETED | (Specify only highest grade co | College (1-4 or 5 - | (G | live kind of Do NOT u | work done | during mo | st of working | g | | - 40 - 1500 | | | |
| MP | 5 | | | Mair | itena | nce | | | | Offi | ce Bu | ild | ing |
| 8 | 17. FATHER'S NAME (First, Middle, Last) Frank Carr | | | | | | | | | Middle, Maiden : Willia | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 10 | h MAII INC | ADDRES | P (Ctunet = | | | | MILILIC | | | |
| 2 | Lucy Dawson | | | | | | | | | lto, Mo | | | |
| | 20a. METHOO OF DISPOSITION | | 20b. PLACE | AND DATE | OF DISPOS | SITION (Ne | | | | E 20c. LOC | | | wn, Stata |
| | Surial 2 ☐ Cremation 3 ☐ Ramovi Donation 5 ☐ Other (Specify) | al from Stata | cemetery_cre Oak | Lawr | ther place) | | | | 9, | /8 Bal | timor | e, | Md. |
| ŀ | 21. SIGNATURE OF FUNERAL SERVICE LICEN | VSEE | | | | | D ADDRES | | | -mal IIa | | | |
| | Kallys X8 | all | MOO | 550 | 7 3 | 000 | E. B | alti | more | e St. E | me Balto, | Md | . 21224 |
| | 23. PART I. Enter the diseases, or con ahock, or heart failure. List IMMEDIATE CAUSE (Final disease or condition | at only ona cau | use on each iine | . | | the mo | de of dyi | ng, sucl | h aa car | diac or reapi | ratory arrea | t, | Approximata Interval Between Onset and Death |
| | resulting in death) a. | DUE TO | (OR AS A CONSE | OUENCE O | F): | | | | | | | | mins |
| Z | Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | mins | |
| CERTIFICATION | Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| 딢 | CAUSE (Disease or injury that initiated events | DUE TO | (OR AS A CONSE | OUENCE O | Timor Fj: | rany | eH | USI | 00 | | | | days |
| FR | resulting in death) LAST | COPD | | | | | | | | | | | |
| | PART ii. Other aignificant conditions | contributing to | death but not i | resulting | in the ur | ndarlyind |) cause d | iven in | Part I. | 24a. WAS AN | AUTOPSY | 24b | WERE AUTOPSY FINDINGS |
| ICAL | CHF bilateral | | | | | | | | | PERFOR | MED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDI | morbid obesity | | | | | | | | | 1 TE3 2 | AL IIIV | | OF DEATH? |
| | DID TOBACCO USE CO | ONTRIBUTE | TO CAUS | SE OF | DEAT | H Y | ES X | NO | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHE | | ACE OF DE | EATH (Che | ock only o | ne) | | | |
| 1×S | 1 YES 2 NO 1 | 26a. DATE OF | ER/Outpatient 3 | | 4 🗆 Nur | sing Hom | e 5 🗆 Re | sidence | | | | | |
| | 1 Natural 5 Pending | (Month, D | | 26b. TIM | JURY M | | URY AT RK? 'ES 2 | NO. | 26d. DE | SCRIBE HOW IF | JURY OCCU | RED | |
| Э ВУ | 2 Accident investigation 3 Suicide 6 Could not be | 26s. PLACE O | F INJURY - At he | me, farm, | atreet, fact | | | , | | CATION (Street a | nd Number or | Rural R | oute Number, |
| Ē | 4 Homicide detarmined | ounding, | atc. (Specify) | | | | | | City | or Town, State) | | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA EXAMINER: | | | | | | | | | | | | and manner as stated. |
| BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | 29c. LICE | NSE NUM | BER | | 29d. DATE S | IGNED | (Month, Day, Year) |
| 10 B | S. Baiky, MD | | | | | | C | 150 | 18 | | 1 9- | 6- | 94 |
| - | 30. NAME AND ADDRESS OF PERSON WHO | | | | | | | | | 0 | | | |
| | 31. DATE FILED (Month, Day, Year) SEP 0 9 1994 | V 32. REGISTRA | AR'S SIGNATURE | yyıe | W M | red i | cal | Can | ter | balt | more | , M | <u>d</u> |
| } | SEP 0 9 1994 | Their Dans | um-Randa | V. | | | | | | | | | |

| | 2. 3 should | | |
|--|--|--|---|
| | E Ame this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 sh | | |
| | sit permit. | | |
| ohysician. | ourial-tran | | |
| ttending p | as the | | |
| spital or a | so to ber | | |
| HYSICIAN; The law requires that the death certificate be executed with ours after death. Page 6 may be retained by the hospital or attending physicials. | be detach | | are marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| retained | 5 should | | notified |
| 6 тау бе | for, page | | nust be |
| th. Page | eral direc | | miner n |
| after deal | y the fun | noval. | cal exa |
| Suno | illed in b | in, or ren | e medi |
| s with | mpletely 1 | crematio | rvent, th |
| executed | in and co | to burial, | umatic e |
| rtificate by | g physicia | with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal | ther tra |
| death ce | attendin | ental Hyg | ry, or 0 |
| hat the | by the | and Me | ny Inju |
| equires t | en signed | of Health | nows a |
| ne law re | has bee | Dept. c | n 23 sl |
| CIAN: TI | ertificate | the State | or Iter |
| IE PHYSI | this c | with . | marked, |
| F | 五五 | 9 | Ē |

BALTIMORE, MARYLAND 21215-0020

SION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL TO THE FUNERAL DE filed within 72 he

Item#1,11 Per F.H. Fi lm# G-715 09/09/94 R.M.

| | | PEPARTMENT (RTIFICATE | OF HEALTH AND ! OF DEATH | MENTAL HYGIEN REG. NO | | | | | | |
|----------------|---|--|-----------------------------------|--|---------------------|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) MILLIE JCMILE | S CURBE | AM | 2. DATE OF DEATH | ~ G4 | 3. TIME OF DEATH | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. lest to $215-14-9529$ A $1 \square$ M $2 \square F$ 78 | YRS. MONTHS C | DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 5 | IRTHPLACE (State or Foreign ountry) Duth Carolina | | | | |
| FOR | De. FACILITY NAME (If not institution, give street and number) LPUINDAIC NUMSing Hon | | 12a (to | EATH | 9c. COUNTY C | OF OEATH | | | | |
| DIRECTOR | TRESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN DIS LOCATION 10d. INSIDE CITY MMITS? 1 V YES 2 | | | | | | | | | |
| | 109. STREET AND NUMBER 101. ZIP CODE 100. CITIZEN OF WHAT 101. ZIP CODE 102. CITIZEN OF WHAT | | | | | | | | | |
| FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Married FORCES? 1 YES 2 KNO | | S DECENDENT OF HISPAR | IIC ORIGIN? (Specify Yes | s or No 14. F | RACE — American Indian, | | | | |
| B≺ | Widowed 4 □ Divorced IF YES, GIVE WAR OR DATES | 10 | YES 2 NO Specifi | | S | specify: Black | | | | |
| COMPLETED | (Give Elementary/Secondary (0-12) College (1-4 or 5+) | EDENT'S USUAL OCCI kind of work done duri to NOT use retired.) | UPATION Ing most of working CUCE | Box (| SINESS/INDUSTF | ty Schools | | | | |
| BE CON | 17. FATHER'S NAME (First, Middle) Last) CONZE LEEKIN | - | | ME (First, Middle, Maider | | 1 | | | | |
| TO B | | MAILING ADDRESS (S | Street and Number or Rural I | Poole Number Sily or Tox | yp, State, Zip Code | d 21215 | | | | |
| | 20a. METHOD OF DISPOSITION 20b. PLACEAN | D DATE OF DISPOSITION OF other piece) | | 9/10/94 P | CATION — City o | or Town, Stata | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NA | 11 01 0 | | Ave | | | | | |
| | 21 PART I. Enter the chaeses, or complications that be used the deeth. Do not enter the mode of dying, such as cerdlec or respiratory arrest, interval Between | | | | | | | | | |
| | iMMEDIATE CAUSE (Final disease or condition resulting in death) e. CARDIAC AIRESS T oue to (or as a consequence of): | | | | | | | | | |
| NOI | Sequentially list conditione, I b. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or injury that initiated evente HYPERTENSION DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| CERT | resulting in death) LAST | | | | | | | | | |
| ICAL | PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURE 246. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 1 YES 2 NO | | | | | | | | | |
| PHYSICIAN: MED | 1 YES 2 | | | | | | | | | |
| SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 W Design 2 FR/Outpetlant 3 | OTHER: | 26. PLACE OF DEATH (Ch | | | | | | | |
| ЭНХ | 27. MANNEB-OF DEATH 28s. DATE OF INJURY | 28b. TIME OF 26 | g Homa 5 Realdence | 6 U Other (Specify) 28d. DESCRIBE HOW | NJURY OCCURE | 0 | | | | |
| B | 1 Metural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation Investigation | | | | | | | | | |
| TED | 3 Suicida 8 Could not be datarmined 28a. PLACE OF INJURY — At home building, atc. (Specify) | s, larm, street, ractory | , отнев | 261. LOCATION (Street City or Town, State | | rel Route Number, | | | | |
| COMPLET | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death one) 2 MEDICAL EXAMINER: On the best of examination and/or inv | | | | | se(a) and manner as stated. | | | | |
| BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUM | | | NEO (Month, Day, Year) | | | | |
| TO B | May and and order of person with the box | | D448 | 317 | > 58 | P.615 1994 | | | | |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM : | 27) (Type, Print) | | | | | | | | |
| | 31. DAYE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE | | | | | | | | | |

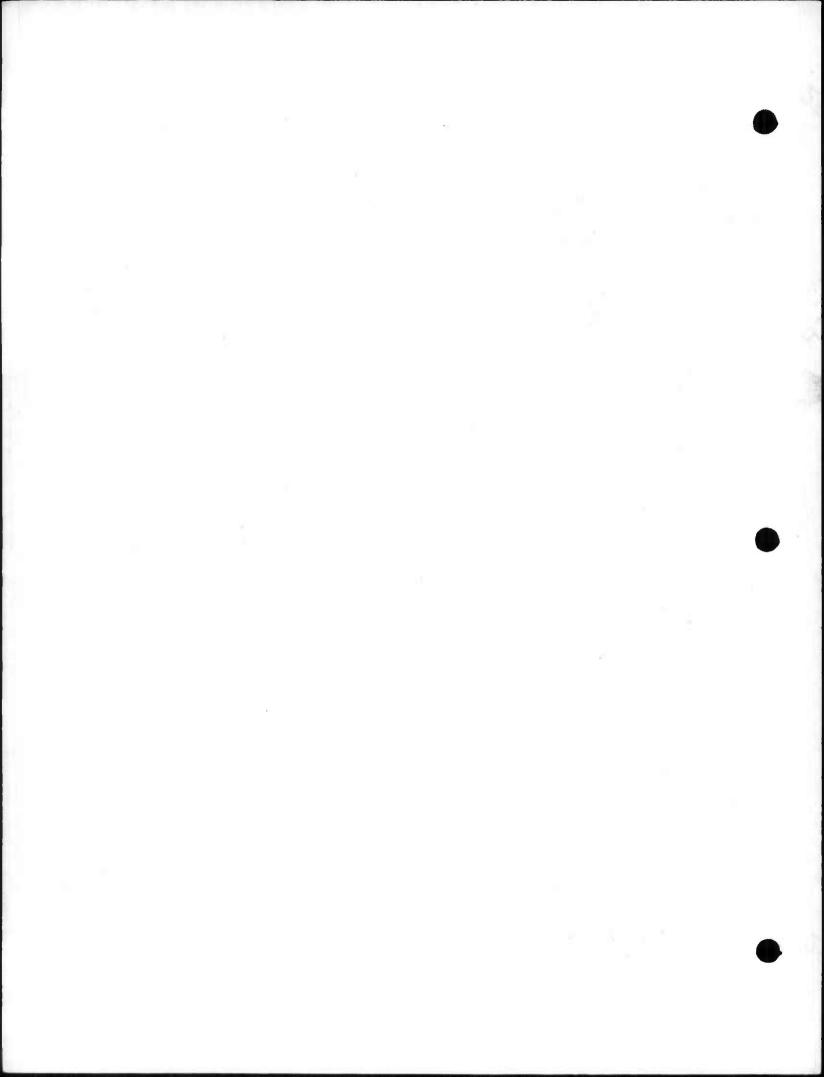
그 ___ 이 시 : (2012년) X.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

FOR 1 - STATE REGISTRAD STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | | HEGISTHAR | | UE. | MIII | CATE | F DEAL | п | REG. NO. | | | |
|--|---------------|--|---|--------------------------|---------------|-----------------|--------------------------|---------------|--|------------------|----------------------|------------------------------|
| | | t. DECEDENT'S NAME (First, Middle, Last) | CHESTE | X | | | | 2 | MONTH 9 | " 3 6 | EAR 3. | TIME OF DEATH 3/3 P M |
| | | 4. SOCIAL SECURITY NUMBER | | GE (In yrs. last | birthday) | IF UNDER 1 YEA | R IF UNDER | 24 HRS 7 | DATE OF BIRTH | 1. | PIRTHE! | ACE (State or Foreign |
| 모 | | 212-03-5706 | t 🗆 M 2 🗁 🗲 | 78 | | MONTHS DAY | | MIN. | (Month, Day, Year) 8 /16 // | | Country) MARYI | |
| 3 should | _ | 9e. FACILITY NAME (If not institution, give st | reet and number) | | 1 | 9b. CITY, TOW | N OR LOCATIO | ON OF DEAT | Н | 9c. COUNTY | OF DEAT | н |
| . 2. | СТОВ | CANINS RESIDENCE OF DECEDENT | | | | BACI | TIMOR | E | | OA | 4 | CITY |
| Pages | Ĭ Ĭ | 10s. STATE 10b. COUNTY | | | 10c. CITY, | TOWN OR LO | CATION | | | | 10 | d. INSIDE CITY |
| permit. Pa | L DIREC | mi | | | 1. | BALT. | Imoke | | | | | LIMITS? YES 2 NO |
| Isi | FUNERAL | 100. STREET AND NUMBER | LETON | 57 | | | 2/2 | | | 10g. CITIZEI | N OF WHA | COUNTRY? |
| physician burial-tra | 5 | 11. MARITAL STATUS | 12. WAS DECEDENT EVE FORCES? 1 YE | R IN U.S. ARM | 4ED | | | | ORIGIN? (Specify Yes | or No- 14 | RACE - | American Indian, |
| attending physe as the bur | BY | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OF | | | | YES 2 JUNO | Specify: | Puarto Rican, etc.) | | Black, W Specify: | BCACK |
| r atter use as | | 15. DECEDENT'S EDUC (Specify only highest grade | | 16a. DEC | EDENT'S U | SUAL OCCUP | ATION most of working | ~ | 16b, KIND OF BUS | SINESS/INDUS | TRY | |
| . 0 - | Щ | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. I | Do NOT use | retired.) | most or working | 9 | | | | |
| hospital ached fo | AP | UNKNOWN | | _L_ | HOM | EMAKER | | | OWN H | OME | | |
| the hospit detached once. | COMPLET | 17. FATHER'S NAME (First, Middle, Lest) | | | | | 18. MOTH | ER'S NAME | (First, Middle, Malden | Surname) | | |
| के देव | w | ROBERT | BUTLER | | | | PRI | SCILI | .A | RO | BINS | ON |
| s retained 5 should notified | 8 | 19s. INFORMANT'S NAME (Type/Print) | | 19b. | MAILING A | ADDRESS (Stre | | | te Number, City or Town | n, State, Zip Co | rde) | |
| be re | 2 | | TURNER | 11 | 2 SO | UTH PC | PPLETO | N STE | REET, BAL | TIMORE | , MD | . 21201 |
| e 6 may ector, pa must b | | 20s. METHOD OF DISPOSITION 1 | | 20b. PLACE AI | | | | (ETED | DATE 200. LO | CATION — CH | or Town, | State |
| Page Il dire | - 53 | 21. SIGNATURE OF FUNERAL SERVICE LIC | | KING P | TEMOR | | AND ADDRES | | | ODLAWIN | , 110 | • |
| ter death. Page 6 m the funeral director, wal. | | · (Karl | 10 | | | JOSE | EPH H. | BROWN | JR. FUN | | | |
| the royal. | \vdash | 23. PART I. Enter the diseases, or c | amplications that are | and the de- | 4. 5. | 11913 | W. BA | LTIMO | DRE ST., | BALTIM | ORE, | MD. 21223 |
| ours after the portion of the medical | | ahock, or heart fallure. | Liat Dnly Dna causa Dr | n aach lina. | iii. Do no | t enter the | mode of dylin | ng, such a | a cardiac or reapl | ratory arres | 1, | Approximate Interval Between |
| filled tion. or the m | | iMMEDIATE CAUSE (Final disease or condition | | | | | | | | | | Onset and Death |
| thin the | | resulting in death) | JEPS1 | | | | | | | | | |
| completely ial, cremati event, t | | | DUE TO (OR A | | , | | | | | | | |
| executed and con o burial, natic er | N | Sequentially flat conditions, | | | | PNE | non | IA | | | | |
| e be execut sician and c prior to buri traumatic | CERTIFICATION | if any, leading to immediate | DUE TO (OR A | S A CONSEQU | UENCE OF): | | | | | | | ĺ |
| ficate be physician ne prior t | 2 | CAUSE (Disease or injury | * | | | | | | | | | |
| ertificat ing phy giene p | Ė | that initiated events resulting in death) LAST | DUE TO (OR A | S A CONSEOL | UENCE OF): | | | | | | | l I |
| eath certi attending rtal Hygie y, or oth | H. | resulting in duality Exer | L | | | | | | | | | |
| he death he atte Mental | | PART II. Other significant conditions | a contributing to death | h but not re | aulting in | the underly | ving cause d | iven in Pa | rt i. 24e, WAS AN | AHTOPSY | 24h WE | RE AUTOPSY FINDINGS |
| that the dea ed by the att th and Menta any Injury, | EDICAL | | | | | | ,, | | PERFOR | | All | MILABLE PRIOR TO |
| requires the sen signed of Health a | ā | | | | | | | | 1 YES 2 | 2000 | | DEATH? |
| | | DID TORACCO USE C | ONITRIBUTE TO | CALIC | - 0- | DEATH | VEC CO | NO. | _ | | t [| YES 2 NO |
| S ep law | AN | DID TOBACCO USE C | ONTRIBUTE IC | CAUS | E OF | | | NO (| | | <u></u> | |
| 日間の | HYSICIAN: M | EXAMINER? | HOSPITAL: | Outpatient 3 | | OTHER: | PLACE OF DE | | Other (Specify) | | | |
| SICIA | Ŧ | 27. MANNER OF DEATH | 26s. DATE OF INJUR | | 28b. TIME | _ | INJURY AT | | d. DESCRIBE HOW II | VJURY OCCUE | RED | |
| | 1 | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year | nr) | INJUI | RY | WORK? | | | | | |
| ATTENDING EGE ZE | 7 | 3 Sulcide 8 Could not be | 26a. PLACE OF INJU building, etc. (S | JRY — At hom Specify) | ne, tarm, str | eet, factory, o | ffice | 28 | It. LOCATION (Street a City or Town, State) | nd Number or | Rural Route | Number, |
| - W S N | | 4 Homicide datarmined | | | = | | | | | | | |
| TAL OR AL DIFF | 집 | | CIAN: To the best of my kn | nowledge, das | th occurred | at the time, o | late and place, | and dua to | the cause(s) and man | ner as atated. | | |
| | CÓMPLE | | R: On the beels of examins | stion and/or in | westigation, | , in my opinio | n, death occure | ed at the tim | e, data and place, an | d dua to the c | ause(a) an | d manner as stated. |
| TO THE HOSPI TO THE FUNEF DE filed within | BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | · nil | | | | 29c. LICE | NSE NUMBE | R | And DATE S | IGNED (M) | Inth, Day, Year) |
| 268₹ | 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF | DEATH (ITEM | 27) (Type, P | Print) | | | | 7 | 17/2 | |
| 2 | | | Oraco, | FML | | | me e | ap | | | | |
| 7 | | 31. DATE FILED (MONT) DOTO SOUTH | 12 DECURTORAL SIST | MOTORE | | | | | | | | |
| | - 1 | | | | - 1 | | | | | | | |

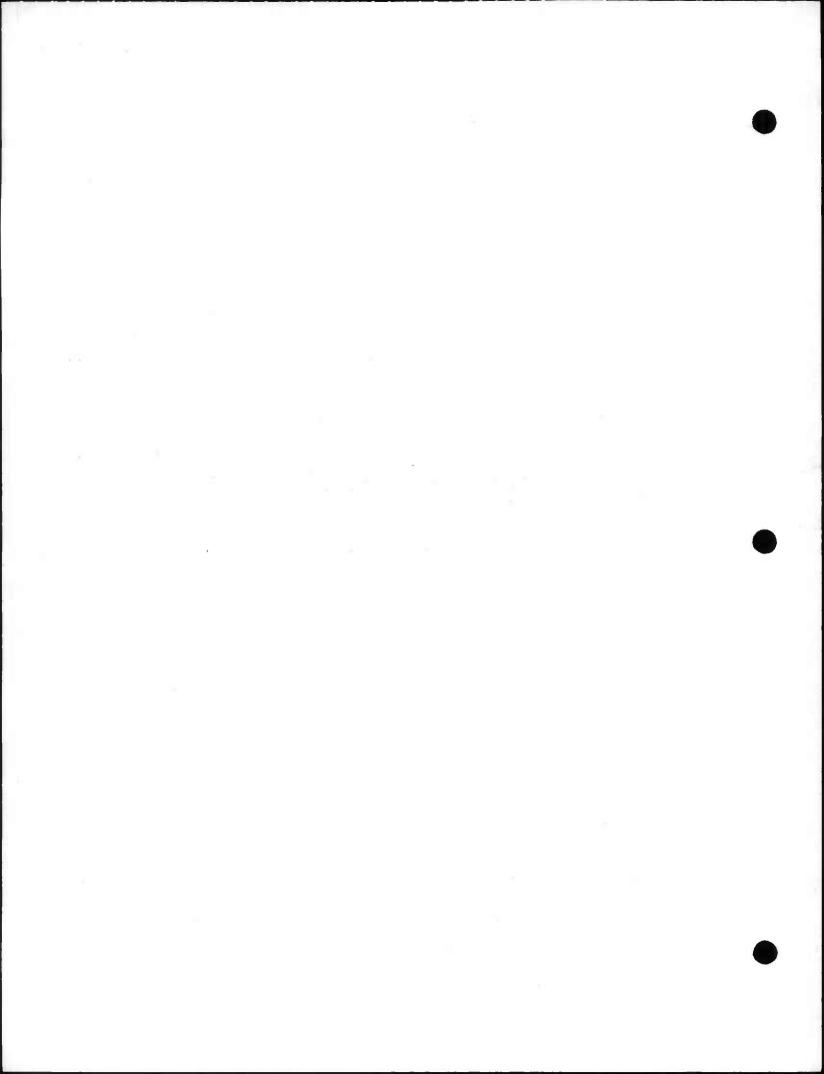


DIVISION OF VITAL RECORDS, P.O. BOX 68760

| = | 50 | 2 |
|--|---|--|
| SECIAN: The law requires that the death certifical | The conficate has been signed by the attending physical | state Dept. of realth and mental hyghene p |
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| STAT | E OF | MARYLAND | 1 | DEPARTMENT | 0F | HEALTH | AND | MENTAL | HYGIENE |
|------|------|----------|---|-------------------|----|--------|-----|--------|----------|
| | | C | E | ERTIFICATE | 0 | F DEAT | H | | REG. NO. |

| | 1 - FOR STATE OF MARYLAND A | | NT OF HEALTH AND | MENTAL HYGIEN | | • | | | |
|-------------|--|---|--|---|--------------------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) Louis Morris Ca | hnet | | | AY YEAR | 3. TIME OF DEATH | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. In | st birthday) IF UN | IDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | 7 94 6. BIRT | THPLACE (State or Foreign | | | |
| | 138-34-5848 1 XM 2 F 51 9a. FACILITY NAME (If not institution, give street and number) | YRS. MONTH | | (Month, Day, Year) 02/16/4 | Jersey | | | | |
| OR | 5700 Carroll Road | | TY, TOWN OR LOCATION OF D | EATH | 9c. COUNTY OF | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | , | N OR LOCATION | | TOBITOI | 10d. INSIDE CITY | | | |
| | Maryland Carroll | | Sykesv | ille | | LIMITS? 1 YES 2 XNO | | | |
| ERA | 100. STREET AND NUMBER 5700 Carroll Road | | 10f. ZIP CODE 2178 | /1 | 109. CITIZEN OF | WHAT COUNTRY? | | | |
| FUNERAL | 11. MARITAL STATUS 1 Never Merried 2 Married 12. WAS DECEDENT EVER IN U.S. AF FORCES? 1 YES 2 N | RMED | 13. WAS DECENDENT OF HISPAI If yes, specify Cuban, Maxica | NIC ORIGIN? (Specify Yes | or No- 14. RA | CE — American Indian, ck, White, atc. | | | |
| B | | White | | | | | | | |
| COMPLETED | (Specify only highest grade completed) | ECEDENT'S USUAL Sive kind of work do b. Do NOT use retire | ne during most of working | | SINESS/INDUSTRY | Securities & | | | |
| MPL | | ock Br | oker | | | agement | | | |
| | 17. FATHER'S NAME (First, Middle, Last) George Cabnet | | THE PART OF THE PA | ME (First, Middle, Meiden Miriam G | | | | | |
| O BE | 19a. INFORMANT'S NAME (Type/Print) 19 | ESS (Street and Number or Rural | Miriam G. Morris d Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | |
| - | Rhoberley Diane Cabnet 5700 Carroll Rd. Sykesville, MD 21784 | | | | | | | | |
| | 1 Burial 2 & Cremation 3 Removal from State 4 Donation 5 Other (Specify) Reference Company Donation State Company Co | Crema | fory, Inc. | 09/08 Ba | 9/08 Baltimore, MD | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSPE | ∉ di | 22. NAME AND ADDRESS OF FA remation So | ciety of | Maryla | nd, Inc. | | | |
| | Dawn F. McDonald 23. PART I. Enter the diseases, or complications that ceused the de | eath. Do not en | 99 Frederic | k Rd. Ba | Itimore | , MD 21228 | | | |
| | shock, or heert fellure. List only one ceuse on each line | ь. | | | enance annum | interval Between Onset and Death | | | |
| | disease or condition resulting in deeth) DUE TO (OR AS A CONSE | OUENCE OF): | a Multifo | RME | | 2 mos | | | |
| N O | Sequentially list conditions. | | | | | | | | |
| SAT | if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | GUENCE OFJ: | | | | | | | |
| RTIFICATION | thet initiated events resulting in death) LAST | OUENCE OF): | | | | | | | |
| AL CE | PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | |
| | | | | PERFOR | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | |
| MEDIC | 1 TYES 2 NO | | | | | | | | |
| PHYSICIAN: | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 125. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | | | | | |
| 148 | ## HOSPITAL: 1 VES 2 NO 1 Inpettent 2 ER/Outpettent 3 27. MANNER OF DEATH 28s. DATE OF INJURY | DOA 4 1 | | 6 Other (Specify) | | | | | |
| BY PI | 1 Netural 5 Pending (Month, Day, Year) 2 Accident investigation | INJURY M | WORK? | 28d. DEŞCRIBE HOW I | NJURY OCCURED | | | | |
| | 3 Suicida a Could not be datarmtned 28s. PLACE OF INJURY — At he building, atc. (Specify) | oma, farm, atreet, t | lactory, offica | 261. LOCATION (Street a City or Town, State) | | Route Number, | | | |
| COMPLETED | 29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, de | ath occurred at th | e time, data and placa, and dua | to the cause(a) and mar | nner as stated. | | | | |
| COM | one) 2 MEDICAL EXAMINER: On the basis of examination and/or | | | | | (a) and manner as stated. | | | |
| й П | 296. SIGNASKINI AND TITLE OF CENTIFIER | | 29c. LICENSE NUI | MBER | | D (Month, Day, Year) | | | |
| 2 | 36. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITE | | 1/40/ | . 0 | 09/0 | | | | |
| | Paul Celano, M.D. 6569 N. (| Charles | Street Ba | ltimore, | MD 212 | 04 | | | |
| | 31. DATE FILED (Month, Down War) 32. REGISTRAR'S SIGNATURE SEP 0 9 1994 Juin Santen Rude | | | | | | | | |



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\$2. REGISTRARIS SIGNATURE A Shieles less

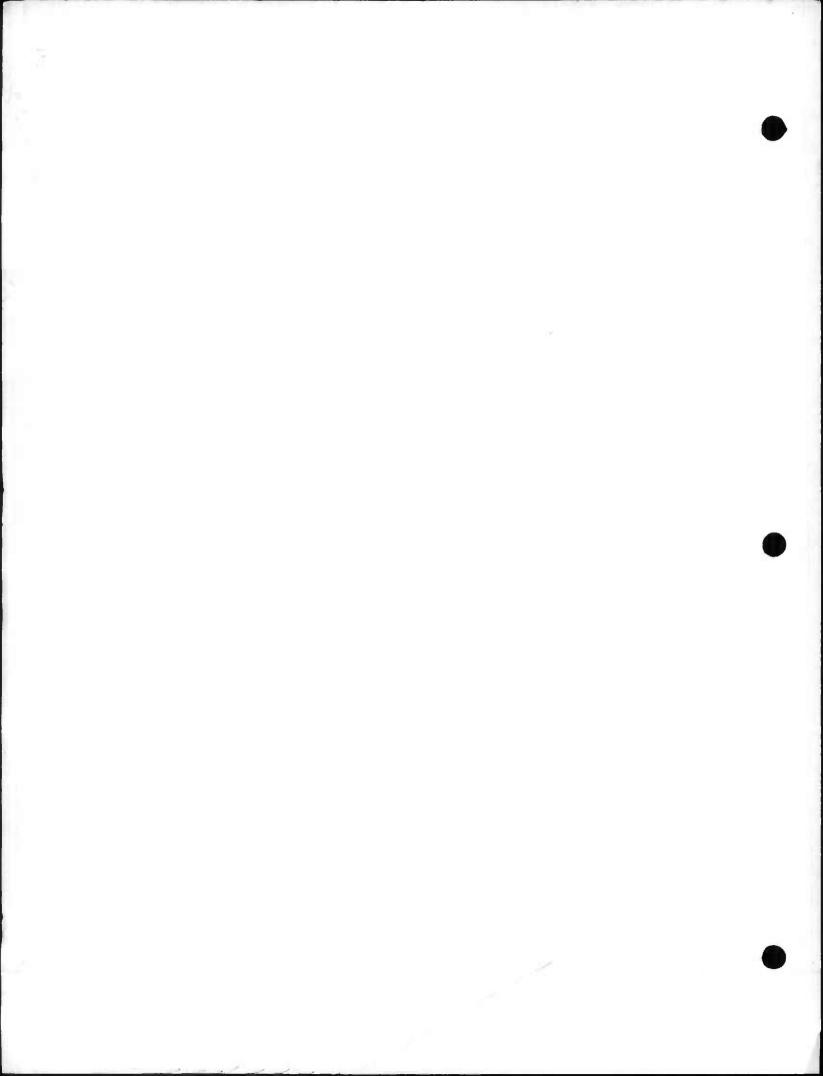
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| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | BALTIMORE, MARYLAND 21215-0020 |
|--|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician. | after death. Page 6 may be retained by the hospital or attending physician. |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should moval. |
| IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | cal examiner must be notified at once, |

1 . FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Blanche Garnant Dodge 09 94 10:20 PM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 7 DATE OF BIRTH 540-42-5915 A 1 DM 2 DXF 92 YRS. HOURS 2-23-02 North Dakota 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN DR I OCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Reeders Memorial Home Boonsboro Washington RESIDENCE OF DECEDENT 10c CITY TOWN OR LOCATION 10d. INSIDE CITY Maryland Washington County Boonsboro 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 101 ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? Reeders Mem Nurs Home 21713 USA Main 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Merried If yes, specify Cuban, Mexican, Puerto Ri 1 YES 2 NO Specify: IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced White ETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 1.1 Rea1 Estate 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) Charles Ε. Garnant Ida BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zio Code) 2 Marilyn Dodge 1567 Andover La, Frederick, MD 21701 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE 4 10 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655 W. Baltimore St, Balto, MD21201 23. PART I. Enter the diseases, Dr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. interval Between Onset and Death **IMMEDIATE CAUSE (Final** disease or condition resulting in death) Perpinatory Failur to me DUE TO (OR AS A CONSEDUENCE OF): to mety Transline Call Carcinome Sledden PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, if any, leading to immediate QUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (DR AS A CONSEDUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE Carting and anen Dichter Malheter 1 | YES 2 | NO Mycholopplans memin 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 4-NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ne 5 🗆 Residence 6 🗆 Other (Specify) 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 4 Natural 5 Pending 1 YES 2 NO BΥ 2 Accident Investigation 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER
(Check only one)

2 MEMORAL EXAMINED: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner es stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE vitalti no D18019 19,694 6 30. NAME AND ADDRESS OF PERSON WHD COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MAGERSTOWN, MOZITYO



ours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

in this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

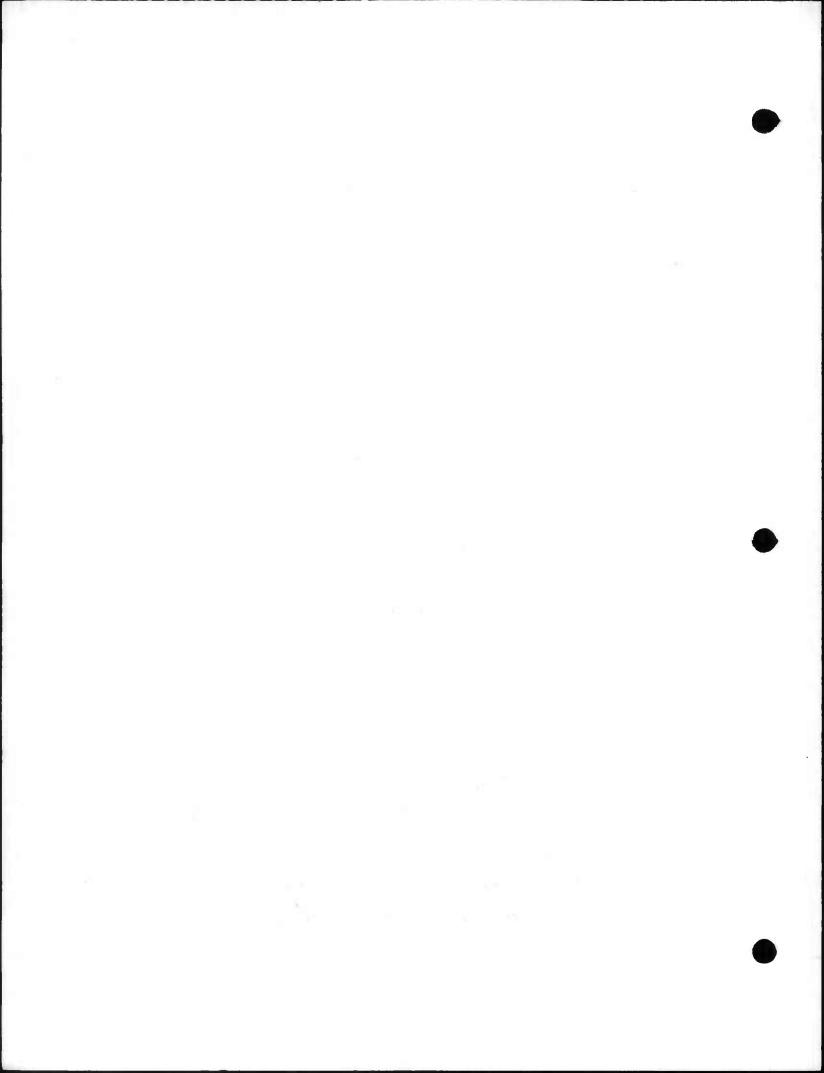
Instructed, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

is PHYSICIAN: The law requires that the death certificate be executed with DIMISION OF VITAL RECORDS, P.O. BOX 68760,

| 100 | Daled. | Chours at |
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| HOSPIN | FUNERA | within 7 |
| 뿚 | 出 | filed |
| 2 | 2 | 2 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPAR CERTIF | TMENT OF I | EALTH AND | | YGIENE EG. NO. | | | | |
|------------------|---|---|---|-----------------------|---------------------------------------|--------------------------------------|---|---------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF E | EATN | | 3. TIME OF DEATN | | |
| | CORNELIUS | DEAN | | | | MONTH 8 | 31 | 199 | Д м | | |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF 8 (Month, De) 9-23- | HRTH (Year) | 8. | BIRTNPLACE (State or Foreign Country) | | |
| | 215-22-8026 9a. FACILITY NAME (If not institution, give : | 142 M 2 D F | 64 YRS. | AL OUTY TOWN | | | | | ORTH CAROLINA | | |
| œ | | | | | OR LOCATION OF D | | | 9c. COUNTY | OF DEATH | | |
| DIRECTOR | 1934 W. FAYETTE STREET BALTIMORE CITY RESIDENCE OF DECEDENT | | | | | | | | | | |
| E | 10a. STATE 10b. COUNT | Y | 10c. CIT | Y, TOWN OR LOCA | TIMORE CI | πv | | | 10d. INSIDE CITY LIMITS? | | |
| | MARYLAND 100. STREET AND NUMBER | | | | | .11 | | | TY YES 2 NO | | |
| RA | 1934 W. FAYETTE S | STREET | | 10 | 1. ZIP CODE 21223 | 3 | | | OF WHAT COUNTRY? | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEOENT EVER IN | N U.S. ARMEO | 13. WAS DEC | ENGENT OF NISPAI | U | | | A • RACE — American Indian. | | |
| | 1 Never Married 2 X Married | FORCES? t X YES IF YES, GIVE WAR OR DA | | If yes, sp | ecity Cuban, Mexica 2 N NO Specifi | in, Puarto Rican | | | Black, White, etc. Specify: | | |
| D BY | 3 Widowed 4 Divorced | ARMY | | | | | | B | LACK | | |
| E | 15, DECEDENT'S EDU (Specify only highest grade | completed) | 16a. DECEDENT'S (Give kind of v iffe. Do NOT us | vork done durina me | ON ist of working | 16b. KIN | D OF BUSIN | ESS/INDUST | TRY | | |
| 1 | Elementary/Secondary (0-12) UNKNOWN | College (1-4 or 5+) | | EKEEPIN(| | ЈОН | NS H | OPKIN | S | | |
| COMPLETED | 17. FATNER'S NAME (First, Middle, Last) | | | | 18. MOTNER'S NA | ME (First, Middle | , Maiden Su | mame) | | | |
| BE C | WILLIAM | DEAN | | | HATTIE | | MI | LLS | | | |
| 2 | 19e. INFORMANT'S NAME (Type/Print) | | | and Number or Rural | | | | | | | |
| | MILDRED DEA | | | | TTE ST., | - | | | | | |
| | 20a. METHOD OF DISPOSITION 1 | | | | | | | | | | |
| | 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIK | CENSEE | ARRISON | | EMETERY OD ADDRESS OF FA | | OWIN | IGS MI | LLS, MD. | | |
| - 1 | ▶ (N ∩ () | D. 00 | ~ \ | JOSEI | PH H. BRO | OWN JR. | FUNE | RAL H | IOME, P.A. | | |
| - | 23. PART I. Enter the diseases, or | complications that cause | d the death. Do n | 1913 | W. BALTI | MORE S | T F | BALTIM | ORE, MD, 21223 | | |
| | shock, or heart failura. | List only one cause on a | ach iina. | or anter the mo | da or dying, suc | n mm cardiec | or respirat | lory arreat, | interval Between | | |
| Ì | IMMEDIATE CAUSE (Final disease or condition | Cardine Ar | cest | | | | | | Onset and Death | | |
| 1 | resulting in death) | a. Carlisc Ar. DUE TO (OR AS A | CONSEQUENCE OF | r): | | | | | | | |
| Z | Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| CERTIFICATION | DUE TO (OR AS A CONSCOUENCE OF): | | | | | | | | | | |
| FIC | cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| E | resulting in death) LAST | | | | | | | | | | |
| | PART II Other significant condition | o contribution to doub b | | | | - | | Patrice . | | | |
| S | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? | | | | | | | | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO | | |
| È | | | | | | | 1 🗆 YES 2 🗩 NO | | COMPLETION OF CAUSE OF DEATH? | | |
| Σ | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | | | 1 TYES 2 NO | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL | | 26. PLACE OF OEAT | | UNCERIAII | 10 | | | | | |
| Sic | EXAMINER? | HOSPITAL: 1 Inpatient 2 ER/Outp | entiant 3 DOA | OTHER: | e 5 🗆 Rasidenca | 6 Other (Spe | iclfy) | | | | |
| 품 | 27. MANNER OF OEATN | 28e. OATE OF INJURY (Month, Day, Year) | 28b. TIMI | | URY AT | 28d. OESCRIB | E NOW INJ | JRY OCCURE | ED | | |
| Z B | 1 Natural 5 Pending 2 Accident Investigation | 9/31/14 | | M 1 🗆 | rES 2 NO | | | | | | |
| | 3 Suicide 8 Could not be 4 Nomicide determined | 28e. PLACE OF INJURY building, atc. (Spec | (Ally) | treet, tectory, offic | | 28f. LOCATION City or Tox | (Street and | Number or R | tural Route Number, | | |
| | An OFFICIER | | Home | | | 1934 | W. Fay | the S | + DHL, AD | | |
| COMPLETED | (Check only | CIAN: To the best of my knowl | | | | | | | | | |
| | 296. SIGNATURE AND WILE OF CHIRAGE | R: On the beals of examination | n and/or investigation | i, in my opinion, d | | | place, and d | iva to the ca | use(s) end manner as stated. | | |
| # | MAHL | 60 | | | 29c. LICENSE NUN | MBER | BER 29d. DATE SIGNED (Month, Day, Year) | | | | |
| 요 📗 | 30. NAME AND ADDRESS OF PERSON WN | O COMPLETED CAUSE OF DE/ | ATN (ITEM 27) (Type, | Print) | 0100) | | | // | 411 | | |
| | Chris Auelino | VA Hospil | | me St. | Bill | MA | | | | | |
| | 31. OATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNA | | 1/10 | 12 115 | , | | | _ | | |
| | SEP 0 9 1994 | 41 | | | | | | | | | |



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760, STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CERTIFIC | ATE O | F DEATH | REG. NO |). | | |
|---------------|--|--|--|---------------------------------------|--|---|---------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | 7 . | | | 2. DATE OF DEATH | AY YE | 3. TIME OF DEATH | |
| | | ewanow | | | | 9 04 | 94 | 11:35 p M | |
| | 218-74-5377 276-29-0762 | 1 - M 2 1 9 | 5 YRS. | F UNDER 1 YEAR | HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Mary 19, 19 | | BIRTHPLACE (State or Foreign Country) [aryland | |
| Œ | 9a. FACILITY NAME (If not institution, give a | | | | N OR LOCATION OF DE | ATH | 9c. COUNTY | OF DEATH | |
| ECTO | Johns Hopkins Ba | yview Medical | Center | Balti | .more | | | | |
| REC | 10a. STATE 10b. COUNT | Υ | 10c. CITY, 1 | TOWN OR LO | CATION | | | 10d. INSIDE CITY | |
| L DIR | Maryland 100. STREET AND NUMBER | | Ba1 | timore | | | | 1 YES 2 NO | |
| ERAL | 526 North Linwoo | d Arronno | | | 21205 | | | OF WHAT COUNTRY? | |
| FUNE | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN | U.S. ARMED | 13. WAS 0 | ECENDENT OF HISPAN | IIC ORIGIN? (Specify Ye | US a or No — 14. | RACE — American Indian, | |
| В | 1 Never Married 2 Married 3 Wildowed 4 Divorced | FORCES? 1 YES IF YES, GIVE WAR OR DAT | | | specify Cuban, Maxica ES 2 NO Specify | | | Black, White, atc. Specify: White | |
| TED | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 16a. DECEDENT'S US (Give kind of work life. Do NOT use r | k done during | ITION most of working | 16b. KIND OF BU | SINESS/INDUST | FRY | |
| COMPLET | Elementary/Secondary (0-12) 2nd | College (1-4 or 5+) | Homemake | , | | Domes | stic | | |
| No. | 17. FATHER'S NAME (First, Middle, Last) | | Homemak | <u> </u> | 18. MOTHER'S NA | ME (First, Middle, Maiden | | | |
| ш | John Behrens | | | | Pe:arl | A. Davis | | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING A | ODRESS (Street | et and Number or Rural F | loute Number, City or Tov | vn, State, Zip Coo | de) | |
| | Lawrence R. Baue | | | | | | | ryland21231 | |
| | 1 ABurial 2 Cremation 3 Ram 4 Donation 5 Other (Specify) | oval from State ceme | PLACE AND DATE OF 1 lery, crematory or other Carmel | r place) | | | CATION — City | or Town, State Maryland | |
| | 21. SIGNATURE OF FUNERAL SERVICE-LI | | · Carmer | | | | | | |
| | 22. NAME AND ADDRESS OF FACILITY David J. Weber Funeral Home 401 South Chester Street Baltimore, Maryland 21231 23. PART I. Enter the diseases, or complications that esused the death. Do not enter the mode of dying, such as cerdiac or reapiratory arrest, Approximete | | | | | | | | |
| ION | IMMEDIATE CAUSE (Final | e. RESPIRAL DUE TO (OR AS A C | | ailw | 4 | | | Interval Between Onset and Death Nour | |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disesse or Injury that initieted evente resulting in deeth) LAST | c. DUE TO (OR AS A 6 | CONSEQUENCE OF): | | | | | | |
| | PART II. Other significent condition | e contributing to death bu | t not reculting in | the underly | ing ceuse given in | Pert i. 24s. WAS AN | | 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO | |
| EDICAL | Urosepsis | 11000 / 70 | 7/ | | | 1 YES | | COMPLETION OF CAUSE OF DEATH? | |
| Σ | _ Congestive | Heart 10 | ulle | | | | | 1 TYES 2 NO | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | 10 to h | ypoal b | | PLACE OF DEATH (CH | Park and and | | | |
| SIC | EXAMINER? | HOSPITAL: | | THER: | ome 5 Rasidenca | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 26b. TIME C | OF 20c. | INJURY AT WORK? | 28d. DEŞCRIBE HOW | INJURY OCCUR | ED | |
| ВУ | 1 Affiturel 5 Pending 2 Accident Investigation | | | M 1 | YES 2 NO | | | | |
| 8 | 3 Suicide a Could not be determined | 28a. PLACE OF INJURY - building, atc, (Specif | At home, term, stra | at, factory, o | fica | 28t. LOCATION (Street City or Town, State | | Rural Route Number, | |
| COMPLET | The state of the s | CIAN: To the best of my knowle | | | | | | suse(a) and manner as stated. | |
| BE | 296. SIGNED THE AND TIPLE OF DESTINA | -mo | | | 29c. LICENSE NUM | | 29d. DATE SI | GNED (Month, Day, Year) | |
| 임 | Seema Kho | | TH (ITEM 27) (Type, Pr | int) | | | n/1 | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNA | | HAT | inns B | ayview | IVIECO | · CTY. | |
| | SEP - 9 1994 July | of Resident Control | | | | | | | |
| | | A POST OF THE PARTY OF THE PART | | · · · · · · · · · · · · · · · · · · · | | | | | |

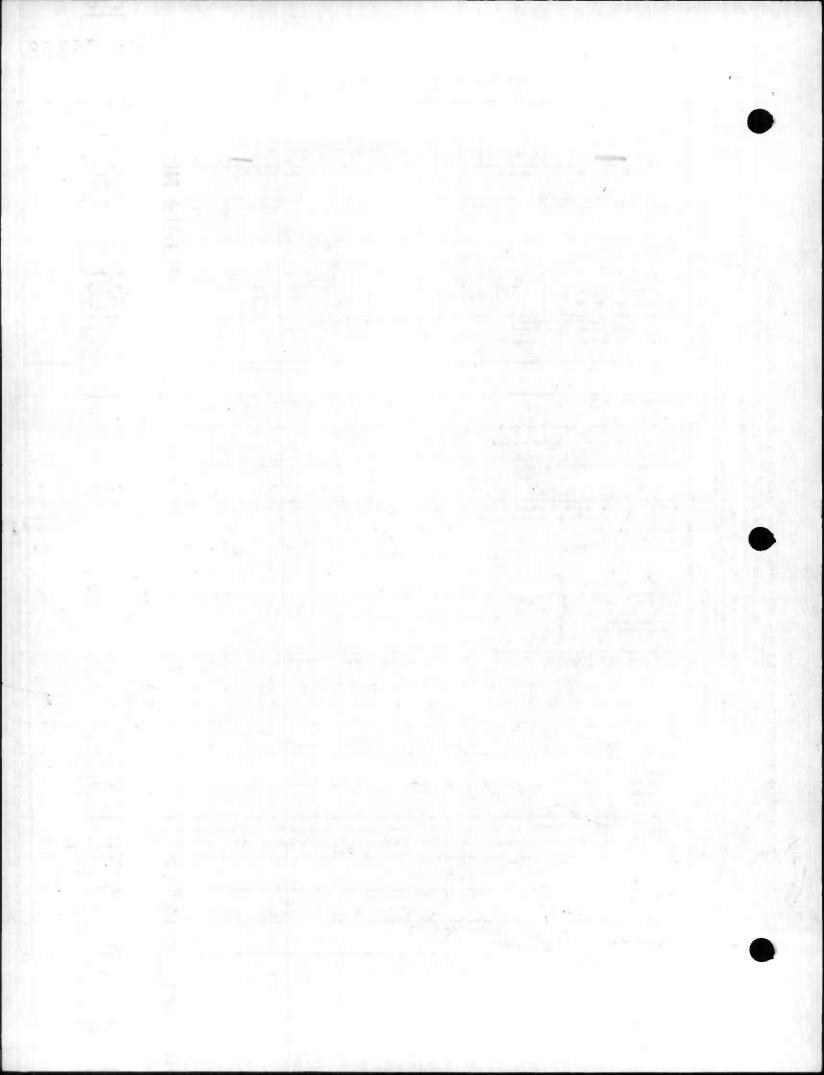
| BOX 68 | avant |
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| a | 2 |
| .O. B(| certificate |
| S, D | death |
| ORD | that the |
| RECO | Familian |
| TAL | The last |
| MINISION OF VITAL RECORDS, P.O. | DENTITEMENT DEVENTABLE. The fact consists that the death certificate he execut |
| VISION | RETENDING |
| = | 000 |

FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. t. DECEDENT'S NAME (First, Middle, Last, 2. DATE OF DEATH 3. TIME OF DEATH Sept. 4,1994 YEAR Anthony J. DeVito 4. SOCIAL SECURITY NUMBER 5 SEY 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER I YEAR IF UNDER 24 HRS. Sopt. 216-52-3850 1 🕎 M 2 🗌 F 45 Maryland 18,1949 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Baltimore City N/A DIRECTOR 5013 Anntana Avenue RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c CITY TOWN OR LOCATION 10d. INSIDE CITY N/A Baltimore City MD. 1 YES 2 NO permit. FUNERAL 10e, STREET AND NUMBER 10f, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 21206 5013 Anntana Avenue funeral director, page 5 should be detached for use as the burial-transit U.S.A. retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1∑ YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Herried If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: Specify: White BY 3 Widowed 4 Divorced Vietnam ED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only h COMPLET ndary (0-12) College (1-4 or 5+) Electrical Technician Westinghouse 12th Grade 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Surname) Joseph A. DeVito to BE Betty Jean Wagner notified 19e. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code), 5013 Anntana Ave. Baltimore, Mary Land 21206 2 Julianne DeVito ours after death. Page 6 may be pe 20e. METHOD OF DISPOSITION
1∑ Buriel 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE must 9-8 Baltimore, Md. Parkwood Cemetery 4 Donation 5 Other (Specify). 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 6415 Belair Road Baltimore, MD. -21206 filled in by the fu John C. Miller, Inc. the medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fallure. List only one cause on each line interval Between cremation, or IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) and completely fill burial, cremation other traumatic event, DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION and Sequantially list conditions, 2 DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING attending physician prior CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 Mental signed by the a PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? WERE AUTOPSY FINDINGS MEDICAL HILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 | YES 2 | NO OF DEATH? 1 YES 2 TNO 6 PHYSICIAN: 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h HOSPITAL: OTHER: 1 YES 2 DY t - Inpetient 2 - ER/Outpetient 3 - DOA ng Home 5 Residence 8 - Other (Specify) 10 27. MANNER OF DEATH 28e, DATE OF INJURY 28b. TIME OF 28c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED this c. marked, t Natural М t YES 2 NO BY After 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be 99 9 DIRECTOR: /
hours after d 4 Homicide COMPLET 29e, CERTIFIER t CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(s) end menner es stated. SPITAL FUNERAL 1 = 2 MEDICAL EXAMINER: On the basis of ex TO THE ACSPITE
TO THE FUNERA
De filed within 7. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED BE 184 0 OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THAN 9101 ANKLIN R 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S PHOTATUR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Iten4,7.Film715,9/9/94.1t



| 020 | physician. |
|--------------------------------|--|
| 215-0 | attending |
| BALTIMORE, MARYLAND 21215-0020 | Page 6 may be retained by the hospital or attending physicia |
| YLA | by the |
| MAR | retained |
| JRE, | 5 may be |
| TIM | . Page (|
| BAL | r death |
| _ | hours af |
| | 47 L |
| 60, | withi |
| (68760, | executed within 24 hours after |

use as the burial-transit permit. Pages 1, 2, 3 should

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the funeral

completely

and

physician

attending

the

signed by the

certificate has been in the State Dept. of

this c. 28 is marked?

death

after

P.0.

The law requires that the death certificate be PHYSICIAN:

OF VITAL RECORDS. NOISINIO TO THE HOSPITAL THE NOT TO THE FUNERAL DIFFERENCE OF FILED WITHIN 72 hours at IMPORTANT: If Item 29

DIRECTOR

FUNERAL

ВУ

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COMPL

BE notified

2

once.

must director,

examiner

medical filled in by t

the cremation.

event,

other Mental Hygiene

10

any injury,

Shows

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Item ;

6

CERTIFICATION

MEDICAL

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1994 YEAR MONTH 9 P M **DEAN** 1:49 Leona Rose 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIFTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign MONTHS DAYS 477-09-4629 77 HOURS 1 🗌 M 2 💢 F YRS. Sept. 18,1916 Minnesota 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF GEATH Franklin Square Hospital Rossville Baltimore County RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore County Baltimore 1 YES 2 NO 10e. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 605 Dale Avenue 21206 U.S.A. 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—II yee, specify Cuben, Mexican, Puerto Ricen, stc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Merried 2 Merried 2 NO 1 TYES 2 X NO Specify 3 🔀 Widowed 4 🗌 Divorced White 16a. DECEOENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) 12th Grade Secretary M.T.A. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Joseph Philippi Elizabeth Lutgen 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael R. Dean 3716 Hilltop Drive, Joppa, Maryland 21085 20s. METHOD OF OISPOSITION

tX☐ Burlet 2 ☐ Cremetion 3 ☐ Ramoval Irom State
4 ☐ Donetion 5 ☐ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE Parkwood Cemetery 9/10 Baltimore, Maryland 22. NAME AND ADDRESS OF FACILITY
John C. Miller, Inc.
6415 Belair Road, Baltimore, Maryland 21206 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiec or reapiratory arrest, shock, or heart tailure. Liet only one couse on each line. Approximate Interval Between IMMEDIATE CAUSE (Final **Onset and Death** diseese or condition_ you phoung resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditione, QUE TO (OR AS A CONSEQUENCE OF) if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST PART ii. Other eigniticant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO mastice tailure COMPLETION OF CAUSE 1 YES 2 NO OF OFATH? 1 _ YES 2 _ NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN I 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: **EXAMINER?** OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 28d. DEŞCRIBE HOW INJURY OCCURED 28b. TIME OF 26c. INJURY AT WORK? 1 Natural 1 YES 2 NO 2 Accident Investigation 26e. PLACE OF INJURY - Al home, larm, street, lectory, office 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide datarmined 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(a) and manner ee stated. 2 MEDIÇAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(e) and menner as stated. 296. SIGNATURE AND TITUE OF CHAPIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

D43420

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)
SEP 0 9 1994



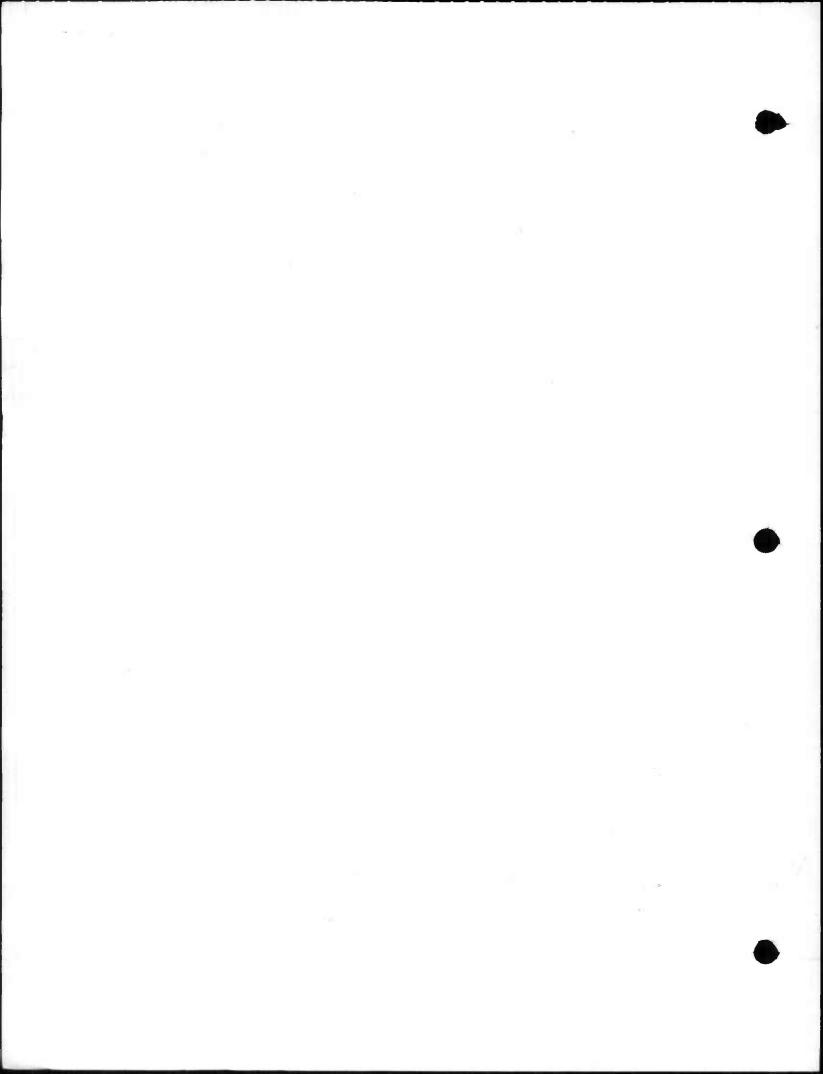
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| DIVISION OF | |

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | | HEGISTHAH | | | ERIT | ICATE | OF L | PEATH | | REG. NO. | | | |
|---|---------------|---|--|--------------------|---|----------------|--------------------------------|---|--------------|-----------------------------|--------------|-------------------------------|---|
| | | 1. DECEDENT'S NAME (First, Middle, Last) Raynard L. Fe | 130% | | | | | | 2. DATE (| DE DEATH DA | | YEAR | 3. TIME OF DEATH |
| | = | 4. SOCIAL SECURITY NUMBER | | 8. AGE (In yrs. Is | nst birthday) | IF UNDER 1 Y | EAR I | IF UNDER 24 HRS. | 7 DATE O | F BIRTH | 5, 194 | | LACE (State or Foreign |
| ᄝ | | 213-84-7818 | X 🛛 M 2 🗆 F | 31 | YRS. | MONTHS | MYS H | HOURS MIN. | FEB" | 3, Year) 1 | 963 | MAR | YLAND |
| 3 shou | œ | 9e. FACILITY NAME (If not institution, give st | | | | | | LOCATION OF D | EATH | , | 9c. COUNT | n/ | |
| 1, 2, | 010 | Union Memori | | | | | | more | | | | | u |
| physician. burial-transit permit. Pages 1, 2, 3 should | DIRECTOR | MARYLAND 106. COUNTY | n/a | | 10c. CIT | Y, TOWN OR BAL | | ÎORE | | | | | 10d. INSIDE CITY LIMITS? YES 2 NO |
| ansit per | FUNERAL | 2839 REMING | STON AV | ENUE | | | 10f. Z | 21211 | | | UN I | TED | STATES |
| iding physician s the burial-tra | ВУ | 11. MARITAL STATUS X Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA | | | If y | S DECEN es, specif YES 2 | IDENT OF HISPAI fy Cuben, Mexica (IX NO Specifi | an, Puerto R | (Specify Yes ican, etc.) | or No- | 14. RACE Black, Specify | - American Indian, White, etc. |
| the hospital or attending detached for use as the once. | COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5+) | - G | ECEDENT'S Give kind of v b. Do NOT us L. A. B.O. | | JPATION ing most o | of working | 16b. | n/a | | STRY | |
| 3 & A | BE CON | 17. FATHER'S NAME (First, Middle, Last) PAUL FELDE | ER | | | | 1 | MAR | | odle, Malden S ORGAN | | | |
| y be retained age 5 should be notified | TO E | 199. INFORMANT'S NAME (Type/Print) MARY C. TY | 'SON | 1 | 9b. MAILING 283 | ADDRESS (S | MIN | Number or Rurel | AVEN | u, City or Town UE, B | State, Zip C | MOR | E,MD#11 |
| death. Page 6 may funeral director, page examiner must b | | 20e, METHOD OF DISPOSITION XIX Burtal 2 Cremetion 3 Ramo 4 Donetion 5 Other (Specify) | | 20b. PLACE | AND DATE O | EMUR I | N (Name | PARK | DATE | | DALL | | WN, MD |
| ter death. Page 6 may be the funeral director, page wai. | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH1101 E. NORTH AVE | | | | | | | | | | | |
| he death certificate be executed within 24 hours after the attending physician and completely filled in by the Mental Hygiene prior to burial, cremation, or removal njury, or other traumatic event, the medical is | CERTIFICATION | 23. PART I. Enter the diseasea, or cehock, or heart failure. If IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (C | e on eech lin | EQUENCE OF | ř): ř): | e mode | or aying, auc | en aa cerdi | ec or reapir | atory arre | at, | Approximate interval Batween Onset and Death 5 days 2 years |
| that the deal led by the att th and Menta any injury, | 11 | PART ii. Other significent conditions | s contributing to d | eeth but not | resulting i | n the unde | riying c | euse given in | Pert i. | 24a, WAS AN A PERFORI | | | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| ires sign Heal | MEDICAL | | | | _ | | | | - | 1 YES 2 | | | AWAILABLE PHIOR TO COMPLETION OF CAUSE OF DEATH? |
| Oept. of | N. W | DID TOBACCO USE CONTR | RIBUTE TO CAU | | | | | UNCERTAI | ИД | | | | |
| tate ta | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | | OTHER: | | 5 | | | | | |
| rySical is certification in the S | PHY | 27. MANNER OF DEATH | 28a. DATE OF IN (Month, Day, | JURY | 28b, TIMI | E OF 28 | c. INJURY | | | RIBE HOW IN | JURY OCCU | IRED | |
| NOING PH R. After th ir death w is mark | D BY | 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE OF building, et | A INJURY — At h | ome, term, s | | _ YES | 2 NO | 28t. LOCA | FION (Street er | nd Number o | r Rural Ro | oute Number, |
| OR ATTE OIRECTO hours afte | LETE | 4 Homicide determined 29e. CERTIFIER 1 CERTIFYING PHYSIC | DIAN: To the beat of m | | eath occurre | d at the time | dete en | d place, and div | | | 10/47 | | |
| TO THE HOSPITAL OR ATTENDING PHYSICI TO THE FUNERAL CIRECTOR: After this cerl be filed within 72 hours after death with the IMPORTANT: If Item 28 is marked, o | COMPLET | one) 1 MEDICAL EXAMINER | | | | | ion, deati | h occured at the | time, date e | | due to the | ceuse(s) | end manner es stated. |
| TO THE TO THE De filed | TO BE | 30 AME AND ADDRESS OF PERSON WHO | YCOMPLETED CAUSE | OF DEATH (ITE | ЕМ 27) (Туре, | Print) | 1 | 9c. LICENSE NUI 47-24 | | 6-A39 | h / | 8 | Month, Day, Year) |
| | | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR | S SIGNATURE | | n P | emi | erial | Hos | sital | | | |
| | | SEP 0 9 1994 | This Dande | n-Kuda | 3 | | | | | | | | |

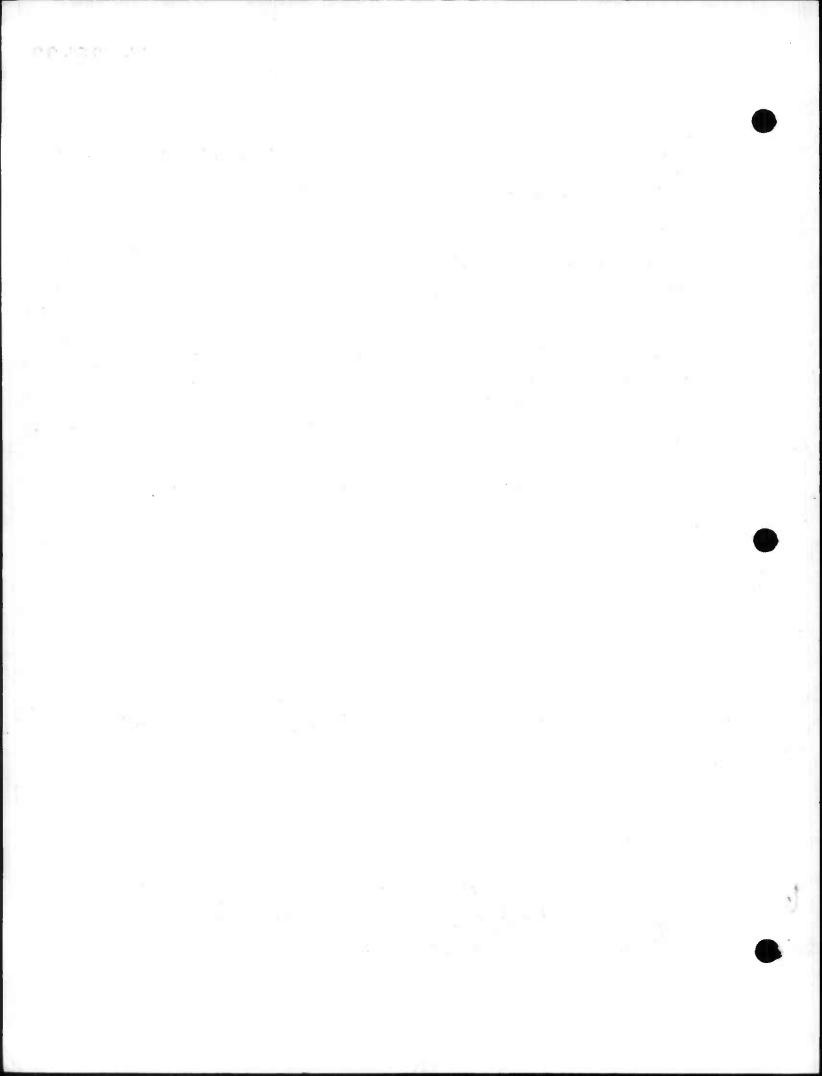


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| | REGISTRAR | NE o. | | | | | |
|------------------------------------|--|--|---|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Las | E FLOG | 90. | | 6/0/6 | DAY Y | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 750-03-4504 90. FACILITY NAME (# not institution, give | 18 M 2 🗆 F 7 | 7 YRS. MONTHS DAY | | 7. DATE OF BIRTH (Month, Day, Ybar) 7 - 22- | 17 | BIRTHPLACE (State or Foreign Country) |
| DIRECTOR | BOR AL | cours Ho | y B | | 2 | 9c. COUNTY | OF DEATH |
| | 10e. STATE 10b. COUNTY 10e. STREET AND NUMBER | NTY | Bal | 101, ZIP CODE | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| FUNERAL | 11. MARITAL STATUS | Har a | em Ave | 2 1 | 217 | 1 | S A SACE — American Indian, |
| В | 1 Never Married 2 Married 3 Wildowed 4 Divorced | | 2 NO If yes | , specify Cuban, Maxica YES 2 NO Specif | in, Puarto Rican, etc.) | | Specify Black |
| COMPLETED | 15. DECEDENT'S EI (Specify only highest gra Elementary/Secondary (0-12) | | 6a. DECEDENT'S USUAL OCCUP (Give kind of work done during life. Do NOT use retired.) | | 16b. KIND OF B | USINESS/INDUS | TRY |
| ш | 17. FATHER'S NAME (First, Middle, Lest) | Floyd | 04.00 | 16. MOTHER'S NA | ME (First, Middle, Meide | on Sumamo) | iams |
| TO B | Armela | L. Floyd | 196 MAILING ADDRESS (STA | eet and Number or Rural | Aoute Number, City or R | own, State, Zip Co | d. 21217 |
| H | 20a, METHOD OF OISPOSITION 1 Buriel 2 Cremetton 3 Re 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE | amoval from State cemete | ery, crematory or other place) | 1 | 9140 | wings V | IIls, Md. |
| | · James | a. Mo | xton Jan | nes A. | Morto | Balton. | ions Md. 21217 |
| | | e. List only one cause on aac | he death. Do not enter the | mode of dying, suc | th as cardiac or res | piratory arrea | |
| NO | IMMEDIATE CAUSE (Finel disesse or condition resulting in death) Sequentisity list conditions. | DUE TO (OR AS A C | onseouence of: Refani | | northe | | |
| ERTIFICATION | disesse or condition | DUE TO (OR AS A C | ONSEQUENCE OF): | | North | | |
| MEDICAL CERTIFI | Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | DUE TO (OR AS A C OUE TO (OR AS A C OUE TO (OR AS A C OUE TO (OR AS A C OUE TO (OR AS A C | ONSEQUENCE OF): | tazi. | Part I. 24a. WAS / | IN AUTOPSY ORMED? 2 JUNE | Onset and Deat |
| MEDICAL CERTIFI | Sequentisify list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions of the condition of the conditions | DUE TO (OR AS A C DUE TO (OR AS A C DUE TO (OR AS A C DUE TO (OR AS A C d. HOSPITAL: | ONSEQUENCE OF): ONSEQUENCE OF): ONSEQUENCE OF): onot resulting in the underly others: | ying cause given in | Part I. 24a. WAS / PERF- 1 VES | ORMED? | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: MEDICAL CERTIFI | Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST PART II. Other significant conditions or injury that initiated events resulting in desth) LAST PART II. Other significant conditions or injury that initiated events resulting in desth) LAST | DUE TO (OR AS A C DUE TO (OR AS A C DUE TO (OR AS A C DUE TO (OR AS A C d. HOSPITAL: 1 Unipatient 2 = ER/Outpett 28e. DATE OF INJURY (Month, Day, Year) | ONSEQUENCE OF): ONSEQUENCE OF): ONSEQUENCE OF): ONSEQUENCE OF): ONSEQUENCE OF): ONSEQUENCE OF): ONSEQUENCE OF): 20 OTHER: 4 Nursing 28b. TIME OF 1NJURY 28c. | ying cause given in | Part I. 24a. WAS / PERF- 1 VES | ORMED? | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| ED BY PHYSICIAN: MEDICAL CERTIFI | Sequentisify list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions of the condition of the conditions | DUE TO (OR AS A C OUE TO (OR AS A C OUE TO (OR AS A C OUE TO (OR AS A C OUE TO (OR AS A C OUE TO (OR AS A C OUE TO (OR AS A C OUE TO (OR AS A C OUE TO (OR AS A C OUE TO (OR AS A C OUE TO (OR AS A C OUE TO (OR AS A C OUE TO (OR AS A C OUE TO (OR AS A C OUE TO (OR AS A C | ONSEQUENCE OF): ONSEQUENCE OF): ONSEQUENCE OF): ONSEQUENCE OF): ONSEQUENCE OF): ONSEQUENCE OF): ONSEQUENCE OF): ONSEQUENCE OF): ONSEQUENCE OF): OTHER: A Unraing 28b. TIME OF INJURY M 1 - At home, farm, street, factory, 4 | ying cause given in B. PLACE OF DEATH (C/ Home 5 Residence INJURY AT WORK? YES 2 NO | Part I. 24a. WAS / PERF- 1 VES seck only one) 8 Other (Specify) | ORMED? 2 JANG V INJURY OCCUR | Onset and Deat 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO |
| ETED BY PHYSICIAN: MEDICAL CERTIFI | Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions are suiting in death) LAST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 MO 27. MANNER OF DEATH 1 Netural 5 Pending investigation inves | DUE TO (OR AS A C DUE TO (OR AS A C DUE TO (OR AS A C DUE TO (OR AS A C DUE TO (OR AS A C DUE TO (OR AS A C DUE TO (OR AS A C DUE TO (OR AS A C DUE TO (OR AS A C DUE TO (OR AS A C DUE TO (OR AS A C DUE TO (OR AS A C DUE TO (OR AS A C DUE TO (OR AS A C DUE TO (OR AS A C DUE TO (OR AS A C DUE TO (OR AS A C | CONSEQUENCE OF): CONSEQUENCE | ying cause given in B. PLACE OF DEATH (C/ Home 5 Residence INJURY AT WORK7 YES 2 NO office | Part I. 24a. WAS A PERF. 1 VES 1 VES 8 Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Town, Steet County or Tow | V INJURY OCCUR | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| ED BY PHYSICIAN: MEDICAL CERTIFI | Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions are suiting in death) LAST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 MO 27. MANNER OF DEATH 1 Netural 5 Pending investigation inves | DUE TO (OR AS A C DUE TO (OR AS | CONSEQUENCE OF): CONSEQUENCE | ying cause given in B. PLACE OF DEATH (C/ Home 5 Residence INJURY AT WORK? YES 2 NO office date and place, and due on, death occured at the 29c. LICENSE NU | Part I. 24a. WAS A PERF- 1 YES 1 YES 26d. DESCRIBE HOW 28f. LOCATION (Stree- City or Town, Ste | V INJURY OCCUP It and Number or hanner se stated, and due to the c | COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO RED Rural Route Number, |

| BALTIMORE, MARYLAND 21215-0020 | v requires that the death certificate be executed with. Thours after death. Page 6 may be retained by the hospital or attending physician. | been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for the burial hygiene prior to burial, cremation, or removal. | |
|--------------------------------|--|--|--|
| RECORDS, P.O. BOX 68760 | nted with | been signed by the attending physician and completely filled in by the fit, of Health and Mental Hygiene prior to burial, cremation, or removal. | |
| 9 X O | be exec | ician and ior to be | |
| O. B | rtificate | ig phys | |
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| S, | he dea | the att | |
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| $\ddot{\circ}$ | Jires 1 | Signe | |
| 8 | v requ | been t. of | |

| | | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AN CERTIFICATE OF DEATH | D MENTAL HYGIENE REG. NO. | |
|--|---------------|--|---|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH MONTH DAY | YEAR 3. TIME OF OEATH |
| | | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vir. last high-day) SE (BIDER 3 VERB SE INDER 24 ME) | 9-7- | 94 1450 PM |
| P | | 218-44-8447 1 1 M 2 XF 47 VRS. MONTHS DAYS HOURS MI | N. (Ponth, 2013-47 | 8. BIRTHPLACE (State or Foreign Country) |
| 2, 3 should | стов | 98. FACILITY NAME (If not institution, give street and number) St. Ganes Tospital Balto | F DEATH 9c. C | OUNTY OF DEATH |
| Pages 1, | DIREC | 100, STATE 106, COUNTY 100, CITY, JOHN OR LOGATION | | 10d. INSIDE CITY LIMITS? |
| sit permit. | FUNERAL (| 10. STREET AND NUMBER 101. ZIP CODE 2 12 | 10g. (| CITIZEN OF WHAT COUNTRY? |
| 020 physician. burial-transit | N N | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HI | SPANIC ORIGIN? (Specify Yes or No- | - 14. RACE - American Indian, |
| 215-0020 attending physician se as the burial-trai | B | | exican, Puerto Rican, etc.) pecify: | Black, White, etc. Specify Black |
| F 2 3 | E | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) [Glive kind of work done during most of working life. Do, NOT usey, etclind) | 16b. KIND OF BUSINESS/ | INDUSTRY |
| | PLE | Elementary/Secondary (0-12) College (1-4 or 5+) | Social S | security Homin |
| YLAND by the hospital by detached it at once. | COMPLET | 17-PATHER'S NAME (First, Middle Last) | NAME (First Middle, Maiden Surname | 0) |
| MAK retained t 5 should notified | TO BE | 190 UNFORMANT'S NAME (Type Print) 190 MAILING ADDRESS (Street and Number or R | ural Route Number, City or Town, State, | Zip Code) 11220 |
| | | 201 PLACE AND DATE OF DISPOSITION | St. Balto, | - City or Town, State |
| Tection E | | 4 Donation 5 Other (Specify) Kingstree Ceneter | y Magy King. | stree, S.C. |
| _ # E # | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | H-West | , |
| EA rs after de removal. | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, | va bash Au | 4. |
| Do ir | | shock, or heart failure. List only one ceuse on each line. | such as cardiac or respiratory | Approximate Interval Between Onset and Death |
| | | disease or condition resulting in death) a. CANCER OF CERVIX | | 4210 |
| D 2 2 2 | | DUE TO (OR AS A CONSEQUENCE OF): | | |
| 8 2 2 E | CERTIFICATION | Sequentielly list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | |
| icate be physician te prior | ICA | CAUSE. (Disease or Injury that Initiated events. DUE TO (OR AS A CONSEQUENCE OF): | | |
| Hygier C | RTIE | that initiated events resulting in death) LAST | | |
| ~ 으로 크 | | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given | n in Part I. 24e. WAS AN AUTOPS | SY 24b. WERE AUTOPSY FINDINGS |
| = 2 2 = | ICAL | | PERFORMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| ₹ Fag Fig C | MEDIC | | | OF DEATH? |
| law law 23 Pept | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO D | |
| = # # = = = = = = = = = = = = = = = = = | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 28. PLACE OF DEATH 28. PLACE OF DEATH OTHER: 1 Inpellent 2 ER/Outpetlent 3 DOA 4 Nursing Home 5 Reside | | |
| | ЭНХ | 27. MANNER OF DEATH 286. DATE DF INJURY 286. TIME OF 28C. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY | OCCURED |
| The Price C | ВУ | 2 Accident Investigation M t YES 2 NO | | |
| | 0 | 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, stc. (Specify) | 28f. LOCATION (Street and Num City or Town, State) | iber or Rural Route Number, |
| HALLAN TA | COMPLET | 29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and medical examines. On the best of examination end/or investigation, in my opinion, death occurred at | | |
| THE HOSPITAL THE FUNERAL filed within 72 | E CC | 29b. SIGNATURE AND JITLE OF CERTIFIER 29c. LICENSE | | DATE SIGNED (MonyA, Day, Spair) |
| TO THE DE filed IMPOR | TO BE | William C Waterfull My Day | 1356 | 9/8/94 |
| | F | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) St Agno | Hospital | 21229 |
| | | 31. DATE FILED (MONTE) DIN 1914 9 32. REGISTRAR'S ENGUATION | | 1 |



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

permit. Pages 1, 2, 3 should

this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit. must be notified at once. er Item 23 shows any injury, or other traumatic event, the medical examiner

Natural Accident

3 Suicide

29e. CERTIFIER

'n

TO BE COMPLET

After

TO THE HOSPITAL DR ATTENDII
TO THE FUNERAL DIRECTOR: A
be filed within 72 hour
IMPORTANT: If item

| | Item#7. G-film per P.H 715 9/9/94 P.C 94 26403 |
|------------------|--|
| | 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REGISTRAR REGISTRAR |
| | 1. DECEDENT'S NAME (First, Middle, Last) SANUEL GAINES 2. DATE OF DEATH S.17PM |
| OR | 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. 474 1/24 8. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS MIN. 1/2 YEAR 1/2 AND MONTHS DAYS HOURS MIN. 1/2 AND MONTHS DAYS MIN. 1/2 A |
| | 98. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL BALTIMORE CITY 96. COUNTY OF DEATH 1 / a |
| FUNERAL DIRECTOR | MARYLAND 10b. COUNTY BALTIMORE 10c. CITY, TOWN OR LOCATION BALTIMORE 11dd. INSIDE CITY LIMITS? 1.XXYES 2 □ NO |
| VERAL | 4506 REISTERSTOWN ROAD 21215 109. CITIZEN OF WHAT COUNTRY? UNITED STATES |
| COMPLETED BY FUN | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 15 YES, GIVE WAR OR DATES 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 YES 2 NO Specify: 15. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. RACE — American Indian, Black, White, etc. 17. Specify: 18. RACE — American Indian, Black, White, etc. 19. Specify: 19. RACE — American Indian, Black, White, etc. 10. YES 2 NO Specify: 11. RACE — American Indian, Black, White, etc. |
| | 18. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) LABORER 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 1 ABORER 1 Bb. KIND OF BUSINESS/INDUSTRY |
| BE CO | 17. FATHER'S NAME (First, Middle, Last) JIM GAINES 18. MOTHER'S NAME (First, Middle, Melden Surreine) OLA DUNNMORE |
| 10 | 196. INFORMANT'S NAME (Type/Print) CARYL GAINES 19b. MAILING ADDRESS (Street and Number of Pairal Pouts Number of |
| | 20c. METHOD OF DISPOSITION W. Burlel 2 Cremetion 3 Removal from State 20c. PLACE AND DATE OF DISPOSITION (Name of Specify) 20c. LOCATION — City or Town, State LANSDOWNE, MD |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH1101 E. NORTH AVE |
| | 23. PARTI. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) COBABLE ARRHYTHMA |
| NO | Sequentially list conditions, A HUPERKALEMA HRS. |
| CERTIFICATION | If any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents |
| | PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS |
| YSICIAN: MEDICAL | AENNECLS GRRHOSIS ANEMIA, DAGOLOPATHY, ALCOHOLISM PERFORMED? 1 YES 2 NO AMILIABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| IAN: | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 28. PLACE OF DEATH (Check only one) |
| HYSIC | EXAMINER? 1 YES 2 DIO 1 Impetient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28. DATE OF INJURY 220 TIME OF 28. INJURY AT 28.4 DESCRIPTO |

28a. DATE OF INJURY (Month, Day, Year)

28e. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify)

OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) 28b. TIME OF 28c. INJURY AT WORK?

28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

MEDICAL EXAMINER:

32 REGISTRAR'S SIGNATURE

SEP - 9 1994

Investigation

20/32 / Mar And 2 H I W

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| cert | ding | 1 |
| death | aften | 1 1-4-1 |
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| hat | 10 | |
| uires t | signe | 1 to take |
| req | peen | , |
| - BW | has | |
| OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 | PTALE DIRECTOR: After this certificate has been signed by the attending physician and completely fi | |
| G P | er th | |
| O | Aff | |
| ATTEN | ECTOR | * |
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|--------------------|---|---|---------------------------------------|------------------------|------------------------------|-------------------------------------|--------------------|--|-----------------|-----------|-----------------------------|--|
| | FOR STATE REGISTRAR | STATE OF MARY | | | MENT OF | | | | GIENE G. NO. | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last | | | | | | | 2. DATE OF DE | ATH DAY | 9 | dear dear | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 216-07-4654 | 5. SEX 6. AG | GE (In yrs. lest bi | | IF UNDER 1 YEAR | - | ER 24 HRS. MIN. | 7. DATE OF BIR (Month, Day, 5-9- | Year) | 5 | Country | PLACE (State or Foreign V) MARYLAND |
| OR | | street and number) | enter | 2 | 9ь. city, тоw | A HIP | | | | | NTY OF D | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUN | тү | | 10c. CITY | TOWN OR LO | CATION | | | | | 1 | 10d. INSIDE CITY |
| DIR | MARYLAND | BALTIMORE | | | BALT | IMOR | Е | | | | | LIMITS? |
| FUNERAL | 1300 WINDLAS | S DRIVE | | | | 101, ZIP CO | DE 21220 |) | | 10g. CIT | US. | VHAT COUNTRY? |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVE FORCES? 1 YI IF YES, GIVE WAR OF | ES 2 NO | D | If yes, | ECENDENT specify Cui ES 2 1 N | ban, Maxica | NIC ORIGIN? (Spenn, Puarto Rican, i | cify Yea | or No | 14. RACE Black Specia | |
| | 15. DECEDENT'S ED | | 16e. DECE | DENT'S | JSUAL OCCUPA | TION | | 16b. KIND | OF BUS | INESS/INC | DUSTRY | WHITE |
| COMPLETED | (Specify only highest grader) Elamentary/Secondary (0-12) UNKNOWN | College (1-4 or 5+) | (Give life, Do | kind of w o NOT use | ork done during retired.) | most of wor | king | _ | Cl | LERI | CAL | |
| MO | 17. FATHER'S NAME (First, Middle, Last) | | | | | | THER'S NA | ME (First, Micidle, | | | OTTE | |
| ELMER E. GENS ROSE | | | | | | | | | | | | |
| 10 | 19a. INFORMANT'S NAME (Type/Print) NANCY E. HUEY | | | | | | | Route Number, City | | | | A 22180 |
| | 20s, METHOD OF DISPOSITION 1 (A Burlal 2 Cremation 3 Pa 4 Donation 5 Other (Specify) | movel from State | 206. PLACE OF other place DRUID | . 1 | | | | | | | City or To | MARYLAND |
| | 21. SIGNATURE OF FUNERAL SERVICE I | - Sect . | 2 | | A. A | LAN S | SEITZ | JR. F | 'UNE | RAL I | HOME | |
| | 23. PART I. Enter the disease, o shock, or heart fellure IMMEDIATE CAUSE (Finel | . Liet Dnly one couse D | n each ilne. | | ot enter the | node of o | | | | | | Approximate Interval Between Onset and Death |
| | diseese or condition resulting in death) | · Kossil | de t | ten | le M | | | | | | | 11-1 |
| | | DUE TO (OR A | AS A CONSEOU | ENCE OF | | 0 | | | | | | 100 |
| TION | Sequentielly list conditione, if any, leeding to immediate | b. DUE TO JOR A | AS A CONSEQU | ENCE OF | <u> </u> | War D | | | | | | 127 |
| CERTIFICATION | cauee. Enter UNDERLYING CAUSE (Disease or injury that initleted evente resulting in deeth) LAST | DUE TO (OR A | AS A CONSEQU | ENCE OF |): | | | | | | | |
| CE | | . d | | | | | | | | | | |
| PHYSICIAN: MEDICAL | PART il. Other algnificent conditi | ona contributing to deet | in but not ree | euiting i | n the underly | ing caus | given in | | PERFOR | | 246 | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| Ē | | | | | | | | ' | YES 2 | □ NO | | DF DEATH? |
| 2 | | | | | | | | | | | | 1 123 2 110 |
| SIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | | PLACE OF | DEATH (C | heck only one) | | | | |
| YSI | 1 TES 2 NO | 1 Inpatiant 2 ER/C | | | | lome 5 🗆 | Raaidenca | e Other (Spec | | | | |
| ву Рн | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJUI (Month, Day, Yel | | 28b. TIMI INJ | URY | INJURY AT WORK? YES 2 | □ NO | 26d. DEŞCRIBE | E HOW IP | JURY OC | CURED | |
| | 3 Suicide e Could not b | 28a. PLACE OF INJ building, atc. (| | e, farm, a | treet, factory, o | ffica | | 2ef. LOCATION City or Tow | | nd Numbe | r or Rumal I | Route Number, |
| COMPLETED | (GINCA OTH) | /SICIAN: To the best of my k | | | | | | | | | | s) and manner as stated. |
| | 296. SIGNATURE AND FITTE OF CERTIF | IER | | | , | | ICENSE NU | | | 29d. DA | TE SIGNED | (Month, Day, Year) |
| TO BE | 30. NAME AND ADDRESS OF PERSON Y | WHO COMBI STED CAUSE OF | 7-75 | 27) (% | Defent) | | D-1 | 42-2-1 | | • | e, | 9. 24 |
| | I JU. NAME AND ADDHEST-OF PERSON \ | VIOLUMPLETED CAUSE OF | CHAIR (ITEM) | ars I hone | PURICI | | | | | | | |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Port 1-7 mg

32. REGISTRAR'S SIGNATURE

SEP 0 9 1994

i Sinden-Ra

DELAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.

The state has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral.

The state Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR. TO THE FUNERAL DATE
DE filed within 72 hours
IMPORTANT: If Item

| | | FOR | |
|---|---|--------------------|--|
| 1 | - | STATE REGISTRAR | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First, | Middle, Last) | | | | | | | | 2. DATE OF I | | | | 3. TIME OF DEATH |
|---------------|---|----------------------------|---------------------------|-------------------------------|---------------------------------|----------------------------|-------------|---------------|-------------|----------------------------|---------------------------|------------|-------------------|---|
| 1/4 | Shirley A | 6W | INN | | | | | | | U 7 | 06 | | YEAR | 6:45 AM |
| | 4. SOCIAL SECURITY NUMB | ER | 5. SEX | B. AGE (In yrs. | last birthday) | _IF UNDE | 1 YEAR | IF UNDER | 1 24 HRS. | 7. DATE OF E | ВІЯТН | | - | PLACE (State or Foreign |
| | 2197601 | 20 | 1 M 2 X F | 36 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, De 5-23-1 | | | Countr | TH CAROLINA |
| - 3 | 9a. FACILITY NAME (If not ins | | treet and number) | | | 9b. CIT | , TOWN (| DR LOCATI | ON OF DE | | 1930 | 9c. COU | NTY OF D | |
| 8 | UNIVERSITY | HOSP | [TAL | | |) | BALT | IMORI | E CIT | Ϋ́ | | | | |
| 5 | RESIDENCE OF DEC | | | | | | | | | | | | | |
| DIRECTOR | 10a. STATE | 10b. COUNTY | Υ | | 10c, CI | ry, town | | | | | | | | 10d. INSIDE CITY LIMITS? |
| | MARYLAND | | | | |] | | | E CIT | Y | | | | 1 X YES 2 NO |
| 34 | 10e. STREET AND NUMBER | | D.M. | | | | 101 | . ZIP COD | | | | | | HAT COUNTRY? |
| FUNERAL | 334 HERRING | COU | | | | | | 2123 | | | | | JSA. | |
| | 11. MARITAL STATUS 1 Never Married 2 | Married | | YES 2 | | 13. | It yes, sp | ecify Cuba | ın, Maxicar | IC ORIGIN? (S | | or No- | 14. RACE Black | — American Indian, c, White, etc. |
| B | 3 Widowed 4 Divor | | IF YES, GIVE Y | MAR OR DATES | | | 1 TYES | 2)(NO | Specify | | | | Special A | |
| B | 15. DECI | EDENT'S EDU | CATION | 16a, | DECEDENT'S | USUAL O | CCUPATION | ON | | 16b. KIN | ID OF BUS | INESS/INC | BLA | ICK . |
| | (Specify only Elementary/Secondary (8- | highest grade | College (1-4 or 5 | | (Give kind of life, Do NOT u | work done ise retired.) | during mo | st of working | ng | | | | | |
| 귤 | 12th GRADE | | | | OTHING | WHOL | ESALE | WORK | ER | | FACT | ORY | | |
| COMPLET | 17. FATHER'S NAME (First, Mi | . , | | | | | | 18. MOT | HER'S NAM | AE (First, Middl | le, Maiden : | Sumame) | | |
| BE (| I.J. GWINN | 1 | | | | | | EV. | A | |] | BURR | IS | |
| 10 | 19a. INFORMANT'S NAME (7) | | | | | | | | | loute Number, C | | | | 04.000 |
| - | EVA | GWIN | N | | 2450 | SOUT | H PA | CA S | TREE | r, BAL | TIMO | RE, I | MARYI | AND 21230 |
| | 20a, METHOD OF DISPOSITION 1 & Buriel 2 Cremation | n 3 🗆 Rem | oval from State | 20b. PLAC | E AND DATE | OF DISPO | SITION (Na | ime of | | DATE | 20c. LO | CATION — | City or To | wn, State |
| | 4 Donation 5 Other | | | MT. | ZION | | | | | | BAL | TIMO | RE, I | 1ARYLAND |
| - 1 | 21. SIGNATURE OF PUNERAL | . SERVICE LIC | CENSEE | 2 | | | | | SS OF FAC | | FIINE | PAT | HOME | , P.A. |
| | LARA | en | 1.1 | 2~ | | | | | | | | | | MD. 21223 |
| | 23. PART I. Enter the di | seasea, or o | complications the | t caused tha | death. Do | not ente | the mo | de of dy | ing, such | aa cardiac | or respi | ratory an | rest, | Approximate |
| | IMMEDIATE CAUSE (Fin | | List only one car | use on aach ii | ne. | | | | | | | | | interval Between Onset and Death |
| | disease or condition resulting in death) | + | · Sees | ک | | | | | | | | | | |
| | | | a. Scps | (OR AS A CONS | SEQUENCE C | F): | - | | | | | | | |
| | | | | | | | | | | | | | | |
| CERTIFICATION | if any, leading to immed cause. Enter UNDERLY | ilata | DUE TO | (OR AS A CONS | SEOUENCE O | PF): | | | | | | | | |
| FI C | CAUSE (Disease or injusting initiated events | | c. DUE TO | (OR AS A CONS | SEQUENCE O | n. | | | | | | | | |
| Ē | resulting in death) LAS | r 📗 | | | | ,- | | | | | | | | |
| 8 | | | d | | | | | | | | | | | |
| MEDICAL | PART ii. Other aignificat | nt condition | a contributing to | death but no | t rasulting | in the u | nderlyin | g cause | given in I | Part I. 24a | PERFOR | | 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| 음 | CHF | | | | | | | | | 18 | YES 2 | | | COMPLETION OF CAUSE OF DEATH? |
| MA M | | | <u> </u> | | | | | | | _ | | | | 1 - YES 2 - NO |
| | DID TOBACCO | O USE | CONTRIBUTI | E TO CA | USE OF | DEA | TH Y | ES [| NO | | | | | |
| CIA | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOSPITAL: | | | OTHE | | ACE OF D | EATH (Che | ck only one) | | | | |
| PHYSICIAN: | 1 YES 2 10 | | 1 Inpatient 2 | | _ | 4 🗆 Nu | | 6 5 R | nsidenca | 8 🗆 Other (Sp | ecify) | | | |
| | 27. MANNER OF DEATH 1 Natural 5 1 | Pending | 28a. DATE OF (Month, I | | 28b. TIR | JURY | | PIC? | | 28d. DEŞCRII | BE HOW IP | NJURY OC | CURED | |
| BY | 2 Accident | nvestigation | 00 01 005 0 | | | М | | YES 2 | NO | | | | | |
| | | Could not be fatermined | building, | of INJURY — At atc. (Specify) | home, term, | street, fac | tory, offic | • | | 281. LOCATIO City or To | N (Street a wn, State) | ind Number | r or Rural A | loute Number, |
| | 29a. CERTIFIER | | | | | | | | | | - | | | |
| MP | (Check only | | CIAN: To the best of | | | | | | | | | | | |
| COMPLETED | | | | samination and/ | or investigati | on, in my | opinion, d | | | | placa, and | | |) and manner as stated. |
| BE | 296. SIGNIATURE AND TITLE | OF CURTIFIE | 7 | | | | | | ENSE NUM | | | 29d. DAT | E SIGNED | (Month, Day, Year) |
| 5 | 30. NAME AND ADDRESS OF | 7- M | 0.0000 | 05.05.05.05 | | | | MR | 018 | 207 | | | 1/6 | 174 |
| | 22 C LI | | | SE OF DEATH (I' | 1 EM 27) (Typ | e, Print) | | | | | | | | |
| | 31. DATE FILED (Month_Day) | Gree | J2. REGISTRA | AR'S SIGNATURE | | | | | | | | | | |
| | 31. DATE FILED (Month Pay | 134 | Jahar Dan | dem Kind | بالباب | | | | | | | | | |
| - 1 | | | V 1 | | | | | | | | | | | |

SHANN IN

| BALTIMORE, MARYLAND 21215-0020 | PLANT. The law requires that the death certificate be executed within. Fours after death. Page 6 may be retained by the hospital or attending physician. | Leate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | e medical examiner must be notified at once. | |
|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE HOSP TAL OF ATTRIBUTE HIS CAN: The law requires that the death certificate be executed within | TO THE FUNETAL DIRECTORATIVE THE CONTINUE AND SHORT SIGNED BY the attending physician and completely filled in by the 1 be filed within 72 hours after the State Dept. of Health and Memai Hyglene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |

TO BE COMPLETED BY FUNERAL DIRECTOR

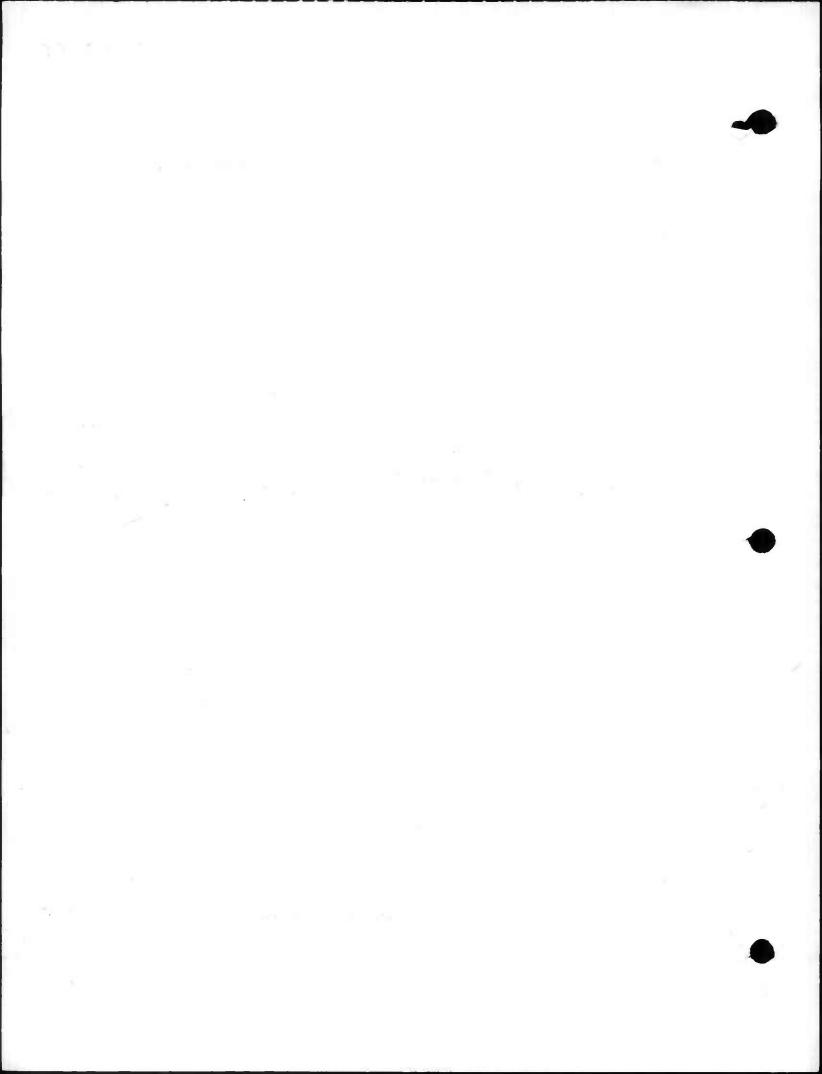
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

31. DATE FILED (Month, Day, Year)
SEP U 9 1994

32. REGISTRAR'S SIGNATURE

| REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) OTIS P. GUYTON CHAPTER OF DEATH STATE OF DEATH OAY 1994 9:30 A 9:30 A 4. SOCIAL SECURITY NUMBER UNKNOWN 1 M 2 F 52 YRS. 6. AGE (In yrs. lest birthdey) 1 MONTHS DAYS HOURS MIN. 1 M 2 F 52 YRS. MONTHS DAYS HOURS MIN. 1 MONTHS DAYS HOURS MIN. 1 MONTHS DAYS HOURS MIN. 1 MONTHS DAYS HOURS MIN. 1 MONTHS DAYS HOURS MIN. 1 MONTHS DAYS HOURS MIN. 1 MONTHS DAYS HOURS MIN. 1 MONTHS DAYS HOURS MIN. 1 MONTHS DAYS HOURS MIN. 1 MONTHS DAYS HOURS MIN. 1 MONTHS DAYS HOURS MIN. 1 MONTHS DAYS HOURS MIN. 1 MONTHS DAYS HOURS MIN. 1 MONTHS DAYS HOURS MIN. 1 MONTHS DAYS HOURS MIN. 1 MONTHS DAYS HOURS MIN. 1 MONTHS DAYS HOURS MIN. 1 MONTHS DAYS HOURS MIN. 1 MONTH DAYS HOURS MIN. 1 MONTHS DAYS HOURS MIN. 2 DATE OF DEATH 2 MONTHS DAYS HOURS MIN. 3 TIME OF DEATH 2 DAYS HOURS MIN. 3 MONTHS DAYS HOURS MIN. 4 MONTHS DAYS HOURS MIN. 5 MONTHS DAYS HOURS MIN. 5 MONTHS DAYS HOURS MIN. 5 MONTHS DAYS HOURS MIN. 5 MONTHS DAYS HOURS MIN. 5 MONTHS DAYS HOURS MIN. 5 MONTHS DAYS HOURS MIN. 5 MONTHS DAYS HOURS MIN. 5 MONTHS DAYS HOURS MIN. 5 MONTHS DAYS HOURS MIN. 5 MONTHS DAYS HOURS MIN. 5 MONTHS DAYS HOURS MIN. 5 MONTHS DAYS HOURS MIN. 5 MONTHS DAYS H | | | | | | | |
|--|--------------|--|--|--|--|--|--|
| 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 1 \(\text{NOWN} \) 5. SEX 1 \(\text{SEX} \) 6. AGE (In yrs. last birthday) 5. SEX 1 \(\text{SEX} \) 6. AGE (In yrs. last birthday) 5. SEX 1 \(\text{SEX} \) 6. AGE (In yrs. last birthday) 5. SEX 1 \(\text{SEX} \) 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 7. AGE (State or Foreign) 7. DATE OF BIRTH 7. AGE (In yrs. last birthday) 7. DATE OF BIRTH 7. AGE (In yrs. last birthday) 7. DATE OF BIRTH 7. AGE (In yrs. last birthday) 7. DATE OF BIRTH 7. AGE (In yrs. last birthday) 7. DATE OF BIRTH 7. | | | | | | | |
| UNKNOWN 1 \(\sqrt{N} \) at 2 \(\sqrt{F} \) 52 \(\text{YRS} \) MONTHS \(\text{DAYS} \) HOURS \(\text{MIN.} \) \(\frac{10 \text{UNKNOWN}}{5 - 20 - 1942} \) \(\text{UNKNOWN} \) 9e. FACILITY NAME (If not institution, give street and number) \(\text{9b. CITY, Town OR LOCATION OF DEATN} \) \(\text{9c. COUNTY OF DEATN} \) | M Z | | | | | | |
| 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN | חן | | | | | | |
| St. South of Beath | | | | | | | |
| 000 1171110 01110 0 0 1 1 1 1 1 1 1 1 1 | | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE CITY | | | | | | | |
| 1 X YES 2 □ NO | | | | | | | |
| 300 MOUNT STREET 101. ZIP CODE 109. CITIZEN OF WHAT COUNTRY? 21223 USA. | | | | | | | |
| 2220 | | | | | | | |
| 12. WAS DECEDENT EVER IN U.S. ARMED 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO If YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 16. RACE — American Indian, Black, White, etc. 17. Specify: | | | | | | | |
| BLACK | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | |
| UNKNOWN College (1-4 or 5 +) UNEMPLOYED | | | | | | | |
| 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | |
| ALBERT PURCELL MARY E. GUYTON | | | | | | | |
| 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | |
| ELLER GUYTON 1419 W. BALTIMORE ST., BALTIMORE, MD. 21223 | | | | | | | |
| 20c. METNOD OF DISPOSITION 20c. LOCATION — City or Town, State 2 | | | | | | | |
| 4 Donation 5 Other (Specify) METRO CREMATORY, INC. 9-8-94 BALTIMORE, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE DICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | |
| JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223 | | | | | | | |
| | 44.3 | | | | | | |
| 23. PART i. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory street, Approximate | | | | | | | |
| shock, or haert fallure. List only one ceuse on each ilne. IMMEDIATE CAUSE (Finel Onset and De | reen | | | | | | |
| interval Betwoods, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. Attrioscleratic cardiovascular disease | reen | | | | | | |
| shock, or haert fallure. List only one ceuse on each ilne. IMMEDIATE CAUSE (Finel disease or condition) At the condition of the condition o | reen | | | | | | |
| shock, or heert failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | reen | | | | | | |
| shock, or heart failure. List only one ceuse on each line. iMMEDIATE CAUSE (Fine) disease or condition resulting in death) a. Attriosclarate Candidovascular disease DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): | reen | | | | | | |
| shock, or heart failure. List only one ceuse on each line. iMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): | reen | | | | | | |
| shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury) Due to (or as a consequence of): | reen | | | | | | |
| shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. Attituselectic conductors culture disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): 24b. WERE AUTOPSY FINDER 24c. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDER | reen eath | | | | | | |
| shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | reen aath | | | | | | |
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| shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. Atticselectic Candidovascular disease DUE TO (OR AS A CONSEQUENCE OF): B. DUE TO (OR AS A CONSEQUENCE OF): | reen aath | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): 1. YES 2 NO DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): 1. YES 2 NO DUE TO (OR AS A CONSEQUENCE OF): 1. YES 2 NO DUE TO (OR AS A CONSEQUENCE OF): 1. YES 2 NO DUE TO (OR AS A CONSEQUENCE OF): 1. YES 2 NO DUE TO (OR AS A CONSEQUENCE OF): 1. YES 2 NO DUE TO (OR AS A CONSEQUENCE OF): 1. YES 2 NO DUE TO (OR AS A CONSEQUENCE OF): 1. YES 2 NO DUE TO (OR AS A CONSEQUENCE OF): 1. YES 2 NO DUE TO (OR AS A CONSEQUENCE OF): 1. YES 2 NO DUE TO (OR AS A CONSEQUENCE OF): 1. YES 2 NO DUE TO (OR AS A CONSEQUENCE OF): 1. YES 2 NO DUE TO (OR AS A CONSEQUENCE OF): 1. YES 2 NO DUE TO (OR AS A CONSEQUENCE OF): 246. WERE AUTOPSY FINDER AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH YES NO UNCERTAIN NO 1. YES 2 NO DUE TO (OR AS A CONSEQUENCE OF): 247. WAS AN AUTOPSY FINDER AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH YES NO UNCERTAIN NO 248. WAS CASE REFERENCED TO MEDICAL EXAMINERS? | reen aath | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not reculting in the underlying cause given in Part i. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 246. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? WYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES OTHER: 1 Inpetient 2 ER/Outpetient 3 DOA A Nursing Nome 5 Residence 8 Other (Specify) | reen aath | | | | | | |
| interval Betwoonset salure. List only ona ceuse on sech lina. IMMEDIATE CAUSE (Fine) disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS | reen aath | | | | | | |
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| Interval Betwonset Causes, or heart failure. List only one ceuse on aech line. IMMEDIATE CAUSE (Fine) disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF) | reen aath | | | | | | |
| Interval Betwonset Cause (Fine) disease or condition resulting in death) Due to (or as a consequence of): | ween aath | | | | | | |
| Intervil Betwoen the countries of the entire filter. List only one ceuse on sech line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury) that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DU | ween aath | | | | | | |
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DIVISION OF VITAL RECORDS, P.O. BOX 6876

| SPITAL OR STENDING THIS | - | THE | 3 | Ã | CIAN: The law requires that the death certific | T Pe | MB. | regi | lires | that | the state | death | certi |
|-------------------------|------|-----|---|---|--|-------|-----|------|-------|------|-----------|----------|-------|
| INCOAL PRE | 0000 | ä | | 1 | and the additional has been signed by the attending of | non h | 4 | 000 | nin | 4 | 400 | a need a | adina |

TO THE HOSPITAL OR TENDING PROJUNISTRE IAW requires that the death certificate be executed within any ours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DRECORE THAT IT certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burla-transit permit. Pages 1, 2, 3 should be filled within 72 neurs and the part of Health and Merial Hygiene prior to burlai, cremation, or removal.

IMPORTANT: If them 23 is married, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

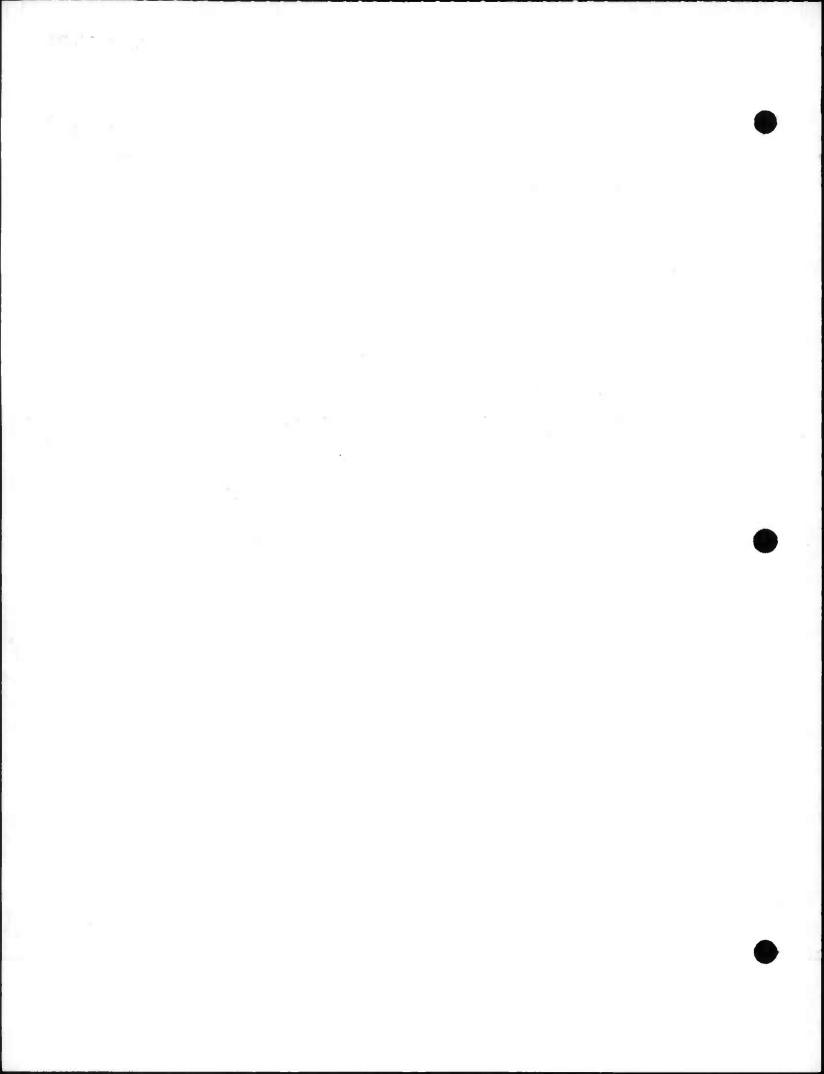
| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
|---|----------|
| CERTIFICATE OF DEATH | REG. NO. |

| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFIC | | | IENTAL HYGIENE REG. NO. | | | |
|-------------------------------------|--|--|--|--|--|---|---|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | |
| | ANNA | | GOODMAN | | | SEPT. 5,1994 | YEAR | 11141 A. | |
| | | | | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | a Dier | HPLACE (State or Foreign | |
| | | 1 - M 2 7 5 | | THS DAYS | HOURS MIN. | FEB. 12,189 | 5 | PUSSIA | |
| _ | 9a. FACILITY NAME (If not institution, give stre | et and number) | 96 | | R LOCATION OF DE | | COUNTY OF | | |
| 6 | 3828 MENLO DRIVE | | 1 | MAZZ | - MOR | F | | | |
| ן ק | RESIDENCE OF DECEDENT | | | | | | | | |
| DIRECTOR | 10a. STATE M 10b. COUNTY | | 10c. CITY, TO | OWN OR LOCAT | ~ / / | | | 10d, INSIDE CITY LIMITS? | |
| | 10e, STREET AND NUMBER | | | 1,00 | ZIP CODE | | | 1 YES 2 NO | |
| FUNERAL | 3278 HEN | 100 Dip. | r | | 2/2/ | 5=343/ | CITIZEN OF | WHAT COUNTRY? | |
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| ᆲ | 1 Never Married 2 Married | 12. WAS DECEDENT EVER IN FORCES? 1 YES | 2 ZNO | 13. WAS DEC | ENDENT OF HISPANI Icify, Çuben, Mexican | C ORIGIN? (Specify Yes or No. Puerto Rican, etc.) | - 14. RAC Blac | E — American Indian, ck, White, atc. | |
| B | Widowed 4 □ Divorced | IF YES, GIVE WAR OR DA | ITES | 1 🗌 YES | | | Spec | WHITE | |
| | 3 | | | l | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade of | ompleted) | 16a. DECEDENT'S USL (Give kind of work | done during mo | N st of working | 16b, KIND OF BUSINESS | INDUSTRY | | |
| | Elementary/Secondary (8-12) | College (1-4 or 5+) | Iffe. Do NOT use rel | | | 3.77.77.77 | | | |
| | 12 | | HOU | SEWIFE | | AT HOME | | | |
| Ö | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAM | E (First, Middle, Maiden Surnan | ne) | | |
| | SAMUEL | | WOLF | | SARA | H | | | |
| H | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING ADI | ORESS (Street a | nd Number or Bural B | oute Number, City or Town, State | Zin Codel | | |
| 일 | MRS. FRANCES BOTW | TNTK | | | | | | | |
| | | | | | ; BALTIMO | | | | |
| | 20a, METHOD OF DISPOSITION 1 N Burlal 2 Cremation 3 Remov | al from State 20b. | PLACE AND DATE OF DI | | | DATE 20c. LOCATION | | | |
| | 4 Donation 5 Other (Specify) | | HAAREI" IF | LLOH - | 9 | -8-94 BALTI | MORE, | AID. | |
| | 21. SIGNATIONE OF FUNERAL SERVICE LICE | NSEE | | 22 NAME AN | ADDRESS OF FAC | BROS., INC. | | | |
| 1 | Diston W. | Deunan | | | | OWN RD. BALT | | MD 21215 | |
| HILLOALION | IMMEDIATE CAUSE (Final disease or condition resulting in death) a. CARDIO - REIF IR ATOXY DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if sny, leeding to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| ≟∥ | CAUSE (Diseese or injury | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | 10.70 | |
| | that initiated events resulting in death) LAST | ASCI | | | | | | <u> </u> | |
| | d. | 7,500 | | | | | | | |
| Ar l | PART II. Other significent conditions | contributing to deeth be | ut not reculting in th | e underlying | ceuse given in F | Part I. 24s. WAS AN AUTOF | SY 241 | . WERE AUTOPSY FINDINGS | |
| | | | | | | PERFORMED? | | AVAILABLE PRIOR TO | |
| | | | | | | | | | |
| 5 | | | | | | 1 YES 2 NO | | OMPLETION OF CAUSE OF DEATH? | |
| | DID TOPAGES WELL | | | | | | | | |
| | DID TOBACCO USE CONTRI | | | | UNCERTAIN | | | OF DEATH? | |
| | 25. WAS CASE REFERRED TO MEDICAL | | 26. PLACE OF DEATH (C | heck only one) | | | | OF DEATH? | |
| | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE OF DEATH (C | heck only one) | UNCERTAIN | | | OF DEATH? | |
| | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | HOSPITAL: Inpetient 2 ER/Output | 26. PLACE OF DEATH (Continued of the con | HER: Nursing Home | Residence 8 | | | OF DEATH? | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | HOSPITAL: | 26. PLACE OF DEATH (Continued of the state o | HER: Nursing Home 28c. INJI | Residence 8 | Other (Specify) | | OF DEATH? | |
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| ED BY PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined | HOSPITAL: Inpetient 2 | 26. PLACE OF DEATH (C stlent 3 DOA 4 D 28b. TIME OF INJURY At home, farm, street | heck only one) HER: Nursing Hom 28c. INJI WO 1 | PS Residence 8 PS Residence 8 PS PS PS PS PS PS PS PS PS PS PS PS PS | Other (Specify) 28d. DESCRIBE HOW INJURY 281. LOCATION (Street and Nur City or Town, State) | OCCURED mber or Rural | DF DEATH? 1 YES 2 NO | |
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| BE COMPLETED BY PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: | AN: To the best of my knowle | 26. PLACE OF DEATH (C atlent 3 DOA 4 D 28b. TIME OF INJURY At home, farm, stree fy) | theck only one) HER: Nursing Hom 28c. INJI WO 1 Y It, tectory, office | S Residence 8 PRES 2 NO PRES 3 NO PRES 2 NO PR | Other (Specify) 28d. DESCRIBE HOW INJURY 281. LOCATION (Street and Nur City or Town, State) the cause(s) and manner as me, data and place, and due | OCCURED mber or Rural stated, to the cause(| DF DEATH? 1 YES 2 NO | |
| IO BE COMPLETED BY PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | AN: To the best of axamination | 26. PLACE OF DEATH (C atlent 3 DOA 4 D 28b. TIME OF INJURY At home, farm, stree fy) edge, death occurred at and/or investigation, in | theck only one) HER: Nursing Hom 28c. INJ WO 1 Y 1, tectory, office the time, date my opinion, de | S Residence 8 PRES 2 NO PRES 3 NO PRES 2 NO PR | Other (Specify) 28d. DESCRIBE HOW INJURY 281. LOCATION (Street and Nur City or Town, State) the cause(s) and manner as me, data and place, and due | OCCURED mber or Rural stated, to the cause(| DF DEATH? 1 YES 2 NO Route Number, | |
| BE COMPLETED BY PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | AN: To the best of my knowle | 26. PLACE OF DEATH (C atlent 3 DOA 4 D 28b. TIME OF INJURY At home, farm, stree fy) edge, death occurred at and/or investigation, in | thetk only one) HER: Nursing Hom 28c. INJI WO 1 T 1, tectory, office my opinion, de | S Residence 8 PRES 2 NO PRES 3 NO PRES 2 NO PR | Other (Specify) 28d. DESCRIBE HOW INJURY 28t. LOCATION (Street and Nur City or Town, State) to the cause(s) and manner as me, data and placa, and due BER 29d. | OCCURED mber or Rural stated, to the cause(| DF DEATH? 1 YES 2 NO Route Number, | |

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FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | | REGISTRAR | | CERTIFIC | CATE OF | DEATH | REG. NO | | |
|---|------------------------|---|---|---|--------------------|-----------------------------|---|--------------------|---|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | Gold | mm | | | 2. DATE OF DEATH | 5 G 15 | 3. TIME OF DEAPH |
| | | 4. SOCIAL SECURITY NUMBER 216-05-7434 | | (In yrs. last birthday) | F UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH | 1912 | BIRTHPLACE (State or Foreign |
| 020 physician. burial-transit permit. Pages 1, 2, 3 should | H. | 9e. FACILITY NAME (If not institution, give s HOWARD COUNTY GET | | | | OR LOCATION OF DE | EATH | 9c. COUNTY HOWA | |
| 1, 2 | 15 | RESIDENCE OF DECEDENT | | | | | | | |
| it. Pages | DIRECTOR | 106. STATE 106. COUNT MARYLAND | HOWARD | | OLUMBI. | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| Perm | A A | 10e. STREET AND NUMBER | | | 10 | 1. ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? |
| nsit | 6 | 6336 CEDAR LANE | APT 374 | | | 21044 | | USA | |
| 215-0020 attending physiclan. use as the burial-tran | BY FUNERAL | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 XXVIIIdowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR | 2 3 TAP | If yes, sp | CENDENT OF HISPAN | HC ORIGIN? (Specify Yee n, Puerto Ricen, stc.) | - | RACE — American Indian, Black, White, etc. Specify: |
| 15-0 tending as the | | | <u> </u> | | | | | | WHITE |
| | 1 = | 15. DECEDENT'S EDU (Specify only highest grade | | (Give kind of wor | k done during me | ON ost of working | 16b, KIND OF BUS | SINESS/INDUST | RY |
| E 5 | COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+) | Ille. Do NOT use CLE | | | | DOGERNI | |
| AND 2 the hospital detached fo | e | | | CLI | | | G. | ROCERY | |
| LA et de | | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Malden | Surname) | |
| AYL of by | ed at | | FFMAN | | _ | HANN | | | ISET EVITTOH |
| MARYLAND retained by the hospit 5 should be detached | TO B | 190. INFORMANT'S NAME (Type/Print) MR. STUART | COLDWAN | 19b. MAILING A | DDRESS (Street | and Number or Rural F | Route Number, City or Tow | n, State, Zip Coo | (e) |
| (U) (E) | De no | | GOLDMAN | 10001 | L WINDS | TREAM DR | IVE, APT. 3 | 02, COLT | JMBIA, MD 2104 |
| BALTIMORE, er death. Page 6 may be the funeral director, page val. | 5 | 20g: METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Rem | oval from State | b. PLACE AND DATE OF | | ame of | DATE 20c. LO | CATION — City | or Town, State |
| O ge o | Hust | 4 Donetion 5 Other (Specify) | M | metery, crematory or othe OSES MONTE | FIORE | 9- | -8-94 BALT | TMODE | MD |
| FIM Page | examiner | 21. SIGNATURE OF FUNERAL SERVICE LIC | | | 22. NAME A | ND ADDRESS OF FA | CILITY | | |
| ALT death. | Eex | | 111 7 | | SOL | LEVINSON | & BROS.,I | NC. | |
| BA after d | | 23. PART I Enter the diseases, pr | 1000 | LIPA | 6010 | REISTERS | STOWN RD B | ALTIMOF | RE. MD 21215 |
| tours af d in by or remo | medical | shock, Di haert fallure. | List only one cause on | eech line. | antar the mo | oda Dr dying, auci | h aa cerdiac or respi | ratory arrest, | Approximate Interval Batween |
| | The The | iMMEDIATE CAUSE (Final disease or condition | 0 -0 | | | | | | Onset and Death |
| within spletely fille cremation, | | resulting in death) | · Sepsi | | | | | | |
| 3760, ted within completely ial, cremat | event, | | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | |
| 68760, executed with and complet b burial, cren | | Sequentially list conditions, | b | | | | | | |
| BOX cate be ex hysician a | ry, or other traumatic | if any, leading to immediate | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | |
| BOX ficate be physician ne prior t | 2 2 | cause. Enter UNDERLYING CAUSE (Disease or injury | c | | | | | | |
| S, P.O. B(death certificate attending physic ental Hygiene pri | - I | that initiated eventa resulting in death) LAST | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | |
| , P.O eath certi attending rtal Hygie | PH | Tooling in doubly Exam | d | | | | | | |
| OS, F ne death the atter Mental | | PART II. Other aignificant condition | a contributing to death | but not resulting in | 1ha underivin | g cause given in | Part i. 24s. WAS AN | ALITOPSY | 24b. WERE AUTOPSY FINDINGS |
| 2 = 3 = | rs any Inju | | | | | g oddoo giveir iir | PERFOR | | AVAILABLE PRIOR TO |
| O transport | <u>a</u> | | | | | | 1 YES 2 | CY/NO | OF DEATH? |
| RECOF w requires that been signed ft. of Health a | | | | | | | _ | | 1 TES 2 NO |
| law law | AN: | DID TOBACCO USE CONT | RIBUTE TO CAUSE (| OF DEATH YES | □ NO □ | UNCERTAIN | <u> </u> | | |
| 一年 皇皇 | PHYSICIAN: M | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEATH | (Check only one) | | | | |
| VIT IAN: Th | YSI | 1 TYES 2 NO | 1 Inpatient 2 ER/Ou | | | ne 5 🗆 Reeldence | 6 Other (Specify) | | |
| OTHYSIC HYSIC With th | PH '9 | 27. MANNER OF DEATH | 28e. DATE OF INJURY (Month, Day, Year) | | OF 28c. IN. | JURY AT DRK? | 28d. DEŞCRIBE HOW II | NJURY OCCURE | D |
| Z 2 2 2 5 2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 | marked BY PI | 1 Natural 5 Pending 2 Accident Investigation | | | | YES 2 NO | | | |
| DIVISION OF VI: DR ATTENDING PHYSICIAN: OIRECTOR: After this certifica nours after death with the St | | 3 Suicide 6 Could not be | 28e. PLACE OF INJUR building, etc. (Spi | Y — Al home, ferm, stre | et, factory, offic | • | 281. LOCATION (Street e | and Number or A | ural Route Number, |
| DIVISI DIRECTOR: Nours after | ETED | 4 Homicide determined | and ing, one top | oony | | | City or lown, State) | | |
| | E H | BUTIFIER 1 X CERTIFYING PHYSI | CIAN: To the beat of my know | wiedne deeth occurred | et the time date | and place, and due | to the assessor and man | | |
| 절절 절 | - 6 | | | | | | | | use(e) end menner ee stated. |
| HOSPITAL FUNERAL Within 72 | BE | × / | | | , -prinority t | | | | |
| 開発 | BE | 295 MENATURE AND TIPLE OF CERTIFIE | 1 0 1 1- | | | 29c. LICENSE NUM | IBER O | 29d. DATE SIC | GNED (Month, Day, Year) |
| 1 228 | D 1 | MOIL WILLIAM | חתניוט | > | | NCO | 108 | - 7/ | 1134 |
| P | | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF D | EATH (ITEM 27) (Type, Pr | int) | P. 1. | | 1 | Nic |
| | | Inm Howers | mo' | 10 22 5 | 75 | Colum! | blanc | 1 51 | 044. |
| | | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIG | NATURE | | | | | |
| | | SEP 0 9 1994 | John Danies | Receive | | | | | |
| | | | 11 | 1 | | | | | |



permit. Pages 1, 2, 3 should

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| Ine iaw requires that the beath certificate be executed within an hours and death. Page 6 may be retained by the hospital or attending physician | cate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tra | | |
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| AMP | as p | State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| ne L | te h | ate C | E |
| - | 23 | St | = |

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this certificate has been with the State Dept. of

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DIRECTOR: /

THE HOSPITAL O THE FUNERAL D filed within 72 h

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PHYSICIAN:

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Item10a, Film715, 9/9/94.1t 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH MONTH ()9 1994" DOROTHY B GENNUSA 06 10:15 DM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year B. BIRTNPLACE (State or Foreign IF UNDER 1 YEAR 229-03-3085 DAYS 81 1 M 2 K F YRS. NOV.15.1912 CALIFORNIA 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN DIRECTOR JOHNS HOPKINS HOSPITAL BALTIMORE CITY 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLADD YORK YORK 1 TYES 2 X NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1710 RANDOLPH DRIVE 17403 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—II yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. RACE — American Indian, Black, While, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Merried 2 N Merried Specify: WHITE 87 1 TYES 2 X NO Specify: 3 Widowed 4 Divorced ETED. 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig College (1-4 or 5+) Elementery/Secondary (0-12) COMPL 4 YRS MUSICIAN BALTIMORE SYMPHONY ORCHESTRA 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) LOFTON BYRD HELEN BROWN 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 1710 RANDOLPH DRIVE - YORK, PA. 17403 MR. IGNATIUS GENNUSA 20e. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE 1 XBurlel 2 Cremetion /3 4 Donation 5 Other Specify JORAVIAN GRAVEYARD 9/9 WINSTON-SALEM, N.C. 21. SIGNATURE OF FUH 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMROE, MD. 21229 23. PART I. Ente Enter the diseases, or complications that caused the de shock, or heart failure. List only one cause on each line and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intarval Batwean IMMEDIATE CAUSE (Final **Onset and Death** disease or condition_ PNEUMONIA ~4 weeks resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CHRONIC OBSTRUCTIVE PULMONARY DISEARE UNKNOWN CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, laading to immadiata cause. Entar UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. CEREBROJASCULAR ACCIDENTS, CHRONIC RENAL INSUFFICIONLY

WITH VEINARY TRACT INFECTION

24b. WERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES TO NO TO LINCED 25. WA

| D TOBACCO OSE CONT | KIBUTE TO CAUSE OF DEATH | | UNCEKIAIN |
|----------------------------|--------------------------|--------------------------|---------------|
| S CASE REFERRED TO MEDICAL | | TN (Check only one) | |
| AMINER? | HOSPITAL: | OTHER: 4 Nursing Nome | 5 Residence 8 |

27. MANNER OF DEATN 1 Natural 2 Accident Investigation 3 Suicide

Could not be

Other (Specify) 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 YES 2 NO 28e. PLACE OF INJURY — At home, ferm, streel, lectory, affice

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and menner ee stated. 2 MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occursd at the lime, date end place, end due to the cause(e) end menner ee stated.

| 8 | IGNATURE AND TI | TLE OF CERTIFI | ER | | | , |
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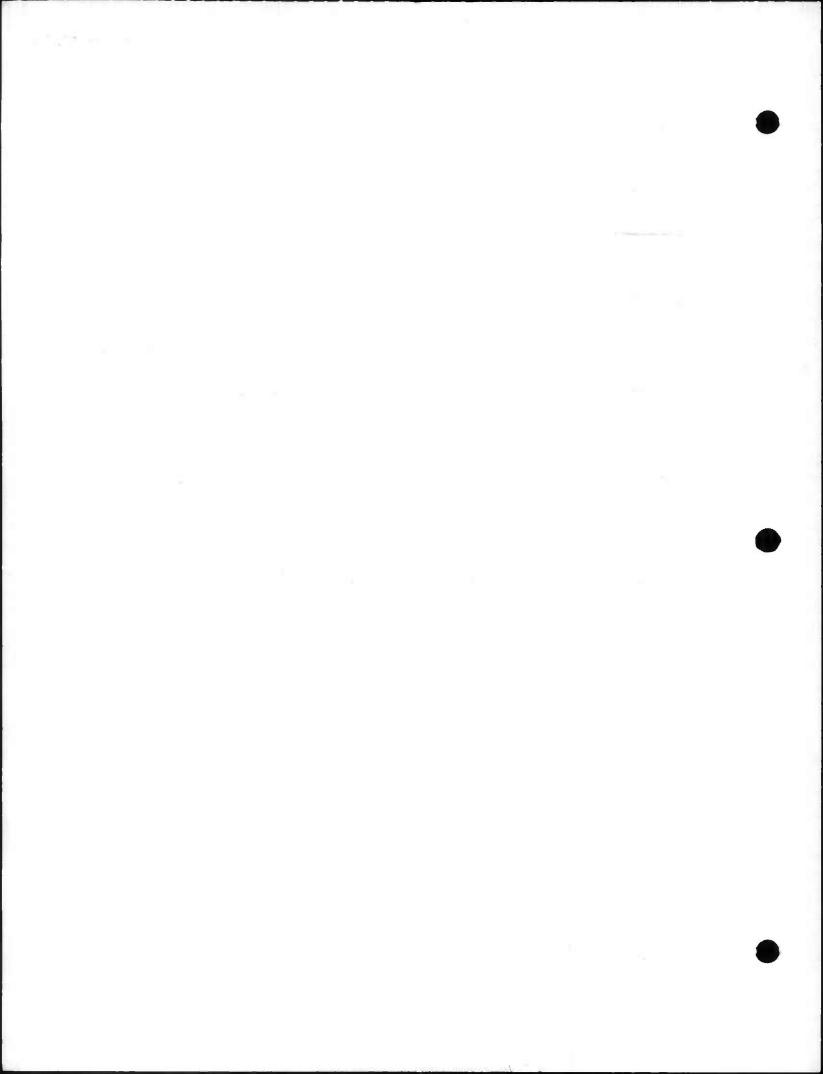
29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year)

KRISTIN THOMAS MD JOHNS HOPKINS HOSPITAL, WOLFE ST.

31. DATE FILED (Month, Pay, Year) 32. REGISTRAR'S SIGNATURE 9 1994

BATTMOREMO



ours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

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COMPLETED BY

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| DIVISION OF VITAL RECORDS, P.O. BOX 68760. BALTIMORE, MARYLAND 21215-0020 | SPITA OR ATTENDING PHYSICAN TRACTION SHALL THE death certificate be executed within cours after death. Page 6 may be retained by the hospital or attending physician. | Uhit on | ked |
|---|---|--|-----------------------|
| DIVIS | TO THE HOSPITAL OR ATTE | TO THE FUNERAL DIRECTOR: After he fled within 70 hours often death | IMPORTANT: If item 28 |
| | | / | 1 |

| | | | | | | | | | | 94 | 26 | 410 | |
|---------------|---|------------------------------|---------------------------|---|---|------------------------|----------|---------------------------------|--------------------------------|---------------|---------------------------|----------------------|--|
| | FOR STATE REGISTRAR | STATE OF N | MARYLAND | / DEPAR | RTMENT OF | HEALTH F DEAT | AND N | MENTAL HYGIEN REG. NO. | | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF DEATH | | | 3. TIME OF E | DEATN | |
| | WILLIE J. | | HAR | HARRISON 8 29 1994 | | | 1994 | | М | | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (In yrs. | last birthday) | IF UNDER 1 YEA | | | 7. DATE OF BIRTH | | S. BIRTNI | PLACE (State | or Foreign | |
| | 212-32-8951 | 1 🔀 M 2 🗌 F | 6 | YRS. | MONTHS DAY | | MIN. | (Month, Day, Year) 8-13-1934 | | SOUT | H CARO | DLINA | |
| ~ | 9a. FACILITY NAME (If not institution, give | | | | 9b. CITY, TOW | | | | 9c. COI | UNTY OF DE | EATH | | |
| Ö | 1207 EDMONDSON A | VENUE | | | BAL | TIMORE | CIT | Ϋ́ | | | | | |
| <u>မှု</u> ၂ | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT | Y | | 100 07 | Y, TOWN OR LO | CATION | | | | | | | |
| DIRECTOR | | | | 100.01 | | | | | | | 10d. INSIDE | | |
| | MARYLAND 100. STREET AND NUMBER | | | | БAL | TIMORE | | <u> </u> | | | 1 VES 2 | | |
| × | 106. STREET AND NUMBER | | | | | 10f. ZIP CODE | | | 10g. CI | TIZEN OF W | HAT COUNTR | 177 | |
| ÿ | 1207 EDMONDSON A | | | _ | | 21 | 223 | | | USA. | | | |
| FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDEN FORCES? 1 | T EVER IN U.S. | ARMED | 13. WAS E | ECENDENT O | F HISPAN | IC ORIGIN? (Specify Yes | or No- | 14. RACE | - American White, atc. | Indian, | |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE W | YES 2X | J.1.0 | | ES 2 X NO | | | | Specif | | | |
| | | | | <u> </u> | | | | BLACK | | | | | |
| TED | ts. DECEDENT'S EDUCATION (Specify only highest grade completed) | | | DECEDENT'S (Give kind of | WORL OCCUPA work done during se retired.) | TION most of workin | g | 16b, KIND OF BUS | 16b. KIND OF BUSINESS/INDUSTRY | | | | |
| 9 | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | ile. Do NOT u | se retired.) | | | 1 | C C | | | | |
| MP | 2ND GRADE | | 1 | LABORI | ER | | | CONSTRU | JCTI(| CTION COMPANY | | | |
| COMPLET | 17. FATNER'S NAME (First, Middle, Last) | | | 16. MOTNER'S NAME (First, Middle, Meiden Surneme) | | | | | | | | | |
| BE | WILLIE | HARRIS | ON | BERNETHA WOODS | | | | 4 | | | | | |
| 5 | 19a. INFORMANT'S NAME (Type/Print) | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | M. | | | | |
| - | BERNETHA HARRI | SON | | 1207 EDMONDSON AVENUE, BALTIMORE, MD. 21223 | | | | | 3 | | | | |
| | 20a. METNOD OF DISPOSITION XX Burlai 2 Cremation 3 Rer | noval from State | 20b. PLAC | PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION City or Town, State | | | | | 5W | | | | |
| | 4 Donation 5 Other (Specify) | | MI. | ZION (| ther place) CEMETER | Y | | 9-6-94 BAL | BALTIMORE, MARYLAND | | | | |
| - 1 | 21. SIGNATURE OF FUNERAL SERVICE L | CENSEE | 7 | _ | | AND ADDRES | | HLITY | | | | | |
| | I Way | -10.11 | 20 | | | | | WN JR. FUN | | | | | |
| | 22 BADT I Esteado discours ou | 1 | | | 191 | 3 W. B | ALTI | MORE ST. | BAL | CIMOR: | | | |
| 1 | 23. PART i. Enter the dieeeses, or shock, or heart fallure. | List only one ceu | se on each li | deeth. Do i ne. | not enter the i | node of dyl | ng, such | sa cardiec or respi | ratory si | rrest, | Approx | ximats si Between | |
| | IMMEDIATE CAUSE (Finel | | | | | | | | | | | and Death | |
| | disesse or condition resulting in desth) | a. DUE TO | E 60 | yo car | DAIS | INFA | 4c770 | 4 | | | MIA | ures . | |
| | | DUE TO | (OR AS A CONS | EOUENCE O | F): | | | | | | | | |
| TION | Sequentially list conditions, if sny, iseding to immediate | b. AYPE DUE TO | R TEUSIU (OR AS A CONS | EOUENCE O | Elfosche Fi: | LATIC | CARD. | ioursuppe | DI. | SEASE | 10 | SED15 | |
| CERTIFICATION | ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated evente resulting in deeth) LAST | C. DUE TO | (OR AS A CONS | EOUENCE O | F): | | | | | | - | | |
| S | | d, | | | | | | | | | + | | |

PART ii. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. De co DONISM

6 ASTEL TIS

GENERALIZED OSTEO PRIMITIS

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) OTHER:

t 🗌 YES 2 🗌 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 28a. DATE OF (NJURY (Month, Day, Year) 1 Natural

2 Accident 8 Could not be 4 Homicide

3 Suicide

CHRONIC

28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)

28b. TIME OF INJURY

28d. DESCRIBE NOW INJURY OCCURED 1 YES 2 NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

24a. WAS AN AUTOPSY PERFORMED?

1 TES 2 THO

29a. CERTIFIER
//Check only

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end manner as stated.

RE.

2 MEDICAL EXAMINER: On the instion end/or investigation, in my opinion, death occured at the time, data and place, and due to the ceuse(s) and menner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

14900

PEMPSYLVAMIA

4 🗆 Nursing Nome 5 🗆 Residence 6 🗆 Other (Specify)

29c. LICENSE NUMBER

28c. INJURY AT WORK?

29d. DATE SIGNED (Month, Day, Year)

AMGE LITA TOPAGO 31. DATE FILED (Month, Day, Year)
SEP 0 9 1994 32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE

1 TES 2 NO

OF DEATH?

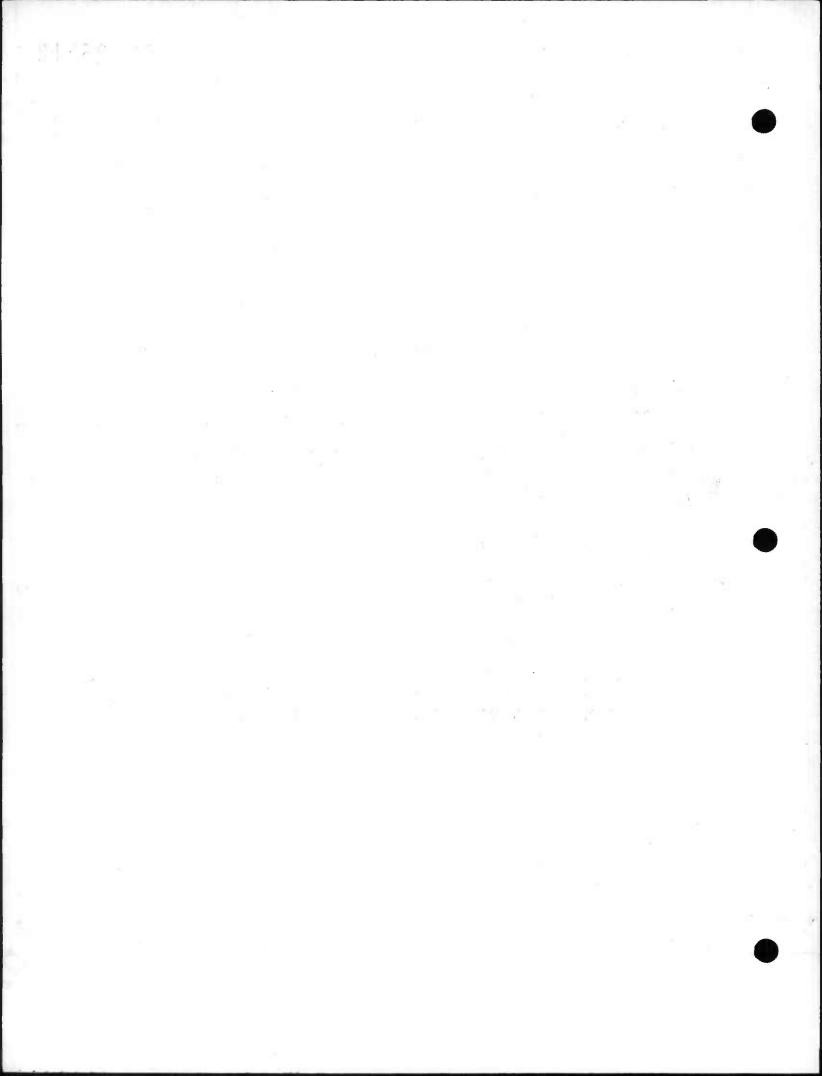
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| 8760, BALTIMORE, MARYLAND 21215-0020 | CHANGE ATTENDING PHYSICIAN: The law requires that the death certificate be executed with ours after death, Page 6 may be retained by the hospital or attending physicial | MECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-th | urial, cremation, or removal. | NET IMEN 28 is marked, or item 23 shows any injury, or other traumatte event, the medical examiner must be notified at once. |
|--|--|--|--|--|
| RECORDS, P.O. BO | w requires that the death certificate | been signed by the attending physic | pt. of Health and Mental Hygiene pri | 3 shows any injury, or other to |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | OR ATTENDING PHYSICIAN: The Ia | DIRECTOR: After this certificate has | In the prior after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal. | them 28 is marked, or item 23 |
| | K | MERAL | 200 | UNT U |

| | FOR STATE REGISTRAR | STATE OF MARYLA | | RTMENT OF H | | | GIENE i. NO. | 4 (| 20411 | | |
|----------------------|--|--|-------------------|------------------|---|---|--|-----------------|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) James | s. | | Huemmer | | 2. DATE OF DEA MONTH Sept. | 6,1994 | YEAR | ME OF BEATH | | |
| | 4. SOCIAL SECURITY NUMBER 215-24-4013 | S. SEX 6. AGE (In yrs. last birthday) F UNDER 1 YEAR F UNDER 1 MONTHS DAYS HOURS | | | | 7. DATE OF BIRT (Month, Day, X 12-19- | DATE OF BIRTH (Month, Dey, Year) 12-19-30 8. BIRTHPLACE (State or Foreign Country) MD | | | | |
| TOR | 9a. FACILITY NAME (If not institution, give so Atlantic General RESIDENCE OF DECEDENT | | | st. city, town o | R LOCATION OF DE | EATH | 9c. COU | COUNTY OF DEATH | | | |
| DIREC | 10a. STATE 10b. COUNTY | Baltimore 10c. CITY, TOWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? 1 \(\text{Y YES } \(\text{\lambda} \) NO | | | | | |
| FUNERAL DIRECTOR | 10. STREET AND NUMBER 4102 Hamilton | Ave. | 101 | ZIP CODE | 206 | 10g. CI1 | 10g. CITIZEN OF WHAT COUNTRY? | | | | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Nidowed 4 Divorced | | | | ENDENT OF HISPAT relfy Cuben, Mexica 2 NO Specifi | in, Puerto Rican, e | | 10.00 | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| COMPLETED | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS: (Give kind of work done during most of working life. Do NOT use retired.) 16c. EEEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | | | | | | |
| BE CON | 17. FATHER'S NAME (First, Middle, Last) Thomas Huemmel | | | | | | Maiden Sumame) iphy y or Town, State, Zip Code) | | | | |
| TOB | 190. INFORMANT'S NAME (Type/Print) Charlot Huemmer | 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | 06 | | |
| | 20e. METHOD OF DISPOSITION 1 M Burlei 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetary or other place) Commetery, cremetary or other place) Carriages OF Faith 9-10-94 Baltimore, MD | | | | | | | | | | |
| | 21. BIGHATUME OF PUNERAL SERVICE LIC | 3. Telles | , | | o adoress of fa n/Bosecia n/Chesaci | | ral Homa | 9 | | | |
| CERTIFICATION | | | | | | | | | Interval Between Onset and Death | | |
| PHYSICIAN: MEDICAL C | PART II. Other significant condition | tension | not resulting | - | cause given in | P1 | AS AN AUTOPSY ERFORMED? YES 2 00 | 24b | WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| ASIC! | 25. WAS CASE REFERRED TO MEDICAL EXAMINERY 1 YES 2 NO | HOSPITAL: | fiert 3 🗆 DOA | OTHER: | ACE OF DEATH ON | | W | | THE REAL PROPERTY. | | |
| ВУ РН | 27. MANNER OF SEATH 1 Natural S Pending 2 Accident Investigation | 28s. DATE OF SNJURY 28b. TIME OF SE. IMJURY AT 28d. DESCRIBE HOW INJURY OCCURE WORK? M 1 YES 2 NO | | | | | | CURED | | | |
| | 3 Suscide 5 Could not be determined 28s. PLACE OF INJURY — At home, farm, street, factory, office 28s. LOCATION (Street and Number or Rural Route Number of Burel Route Number of Rural Route Number o | | | | | | | | | | |
| COMPLETED | | CIAN: To the best of my knowle R: On the bests of examination | | | | | | | a) and menner as stated. | | |
| O BE | 296. SIGNATURE AND TITLE OF CERTIFIER | Mana | | | 29c. LICENSE NUI | MBER 075 | 29d. DA | TE SIGNED | (Month, Day, Year) | | |
| | 30. NAME IND ADDRESS OF PERSON WH | | TH (ITEM 22) (TYP | Print) | - / | nD | | | | | |
| | SEP U 9 1994 | 32. REGISTRAR'S SIGNA | | | | | | | | | |

DIVISION OF VITAL RECORDS P.O. BOX 68760

| | | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTME CERTIFICA | | | MENTAL HYGIEN | | | |
|--|---------------|--|---|---|--|---|---|---|---|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) ELEANORA | C. HARG | ADN | | _ | 2. DATE OF DEATH | W 6 9 | 3. TIME OF DEATH 5:45 P M | |
| <u> </u> | | 4. SOCIAL SECURITY NUMBER 218-08-4815 | 1 □ M 2 🔀 F 73 | In yrs. last birthday) IF UN YRS. MONTH | DER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BUTTH (Morth, Day, Year) APRIL 1,1 | C | INTHPLACE (State or Foreign ountry) ARYLAND | |
| 2, 3 should | TOR | 9a. FACILITY NAME (If not institution, give stated of the state of the stated of the s | | 96. С | | FIMORE | EATH | 9c. COUNTY | DF OEATH | |
| . Pages 1. | DIRECTO | 10e. STATE 10b. COUNTY MARYLAND | | 10c. CITY, TOW | | TIMORE | | | 10d. INSIDE CITY LIMITS? 1 7 YES 2 NO | |
| physician. burlal-transit permit. Pages 1. | FUNERAL | 106. STREET AND NUMBER 3511 McTAVISH AVE | NUE | | | 21229 | | | OF WHAT COUNTRY? | |
| | ETED BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 XWidowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 X NO | If yes, sp | ENDENT OF HISPAI ecify Cuban, Maxics 2 NO Specifi | NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.) ly: | a or No— 14, 1 | RACE — American Indian, Black, White, atc. Specify: | |
| r attend use as | | 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) | ATION completed) College (1-4 or 5+) | (Give kind of work do life. Do NOT use retire | CEDENT'S USUAL OCCUPATION We kind of work done during most of working Do NOT use retired.) | | | | WHITE | |
| the hospital or detached for once. | COMPL | 8TH GRADE 17. FATHER'S NAME (First, Middle, Last) | | HOMEMAKER | | 1 | ME (First, Middle, Maiden | MAKING Surname) | | |
| retained by 5 should be notified at | AD 190. 8 | ADAM BATZ 190. INFORMANT'S NAME (Type/Print) JOSEPH W. HARGAD(| ON | 194 | | and Number or Rural | ERINE ROSS Route Number, City or Tow | | ») | |
| e 6 may be rector, page | | 20a. METHOD OF DISPOSITION 1 XBuriet 2 Cremetion 3 Remode 4 Donation 5 Other (Specify) | vet from State 20b | PLACEAND DATE OF DISP etery, crematory or other pla udon Park C | POSITION /Na | ame of | | CATION — City | 1012 or Town, Stata | |
| death. Page funeral dir | | 21. SIGNATURE OF FUNERAL SERVICE | met D | H | 22. NAME AN IUBBAR | D FUNERA | L HOME, IN | NC. | E, MD. 21229 | |
| ted with hours after completely filled in by the fall, cremation, or removal event, the medical | | 23. PART I. Enter the disease, or c shock, or heert fellure. I IMMEDIATE CAUSE (Final disease or condition resulting in death) | omplications that ceused list only one cause on e | the deeth. Do not en ech line. | ter the mo | de of dying, suc | th as cardisc or resp | lratory srrest, | Approximate Interval Between Onset and Death | |
| th certificate be executed ending physician and con I Hygiene prior to burial, or other traumatic er | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST | DUE TO OR AS A DUE TO OR AS A DUE TO OR AS A | consequence of: heart dise consequence of: bestruc | ver ase | lobe p | neumonia itral valve | raplace | nent | |
| w requires that the d been signed by the it. of Health and Mel | IAN: MEDICAL | Chronic repul | Thmias he | patitis 2° | Amio | g couse given in largere year 20 yr ey YES X No | PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| SICIAN: The lar certificate has the State Der | HYSIC! | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outp | | IER: Nursing Hom | | 8 Cher (Specify) | | | |
| ATTENDING PHYSICIAN: The ETITH After this certificate h, death with the State C Z marked, or Item | ву Рн | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 10, | YES 2 NO | 28d. DESCRIBE HOW | | | |
| OR ATTEND DIRECTOR | 8 | 3 Suicide 6 Could not be 4 Homicide datarmined | building, atc. (Spec | | | | 281. LOCATION (Street City or Town, State |) | rel Route Number, | |
| A S | COMPL | (Check only | CIAN: To the best of my knowless: On the beals of examination | | | | | | ree(s) and manner as stated. | |
| TO THE HOSP TO THE FUNE De find within | TO BE | Stannie L | inder 1 | MS | | 29c. LICENSE NUI | MBER 9 | 29d. DATE SIGNED (Month, Day, Year) Suptember 6, 1994 | | |
| | | 30. NAME AND ADDRESS OF PERSON WHO | 516 N. | Rolling Ro | 6. (| latons vi | lle MO | 2/22 | 8 | |
| | | "SEP 0 9 1994 | 32. REGISTRAR'S SIGN | | | | | | | |



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| DIVISION OF VITAL RECORDS, | STAIL OF ATTENDISC DUNCHEST TO |
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31. DATE FILES (Month, Day, Year) 1994

FOR STATE REGISTRAR 2. DATE OF DEATH 9-7-94 1. DECEDENT'S NAME (First Middle Last) WALTER HOOVER, HOWARD 3. TIME OF DEATH 150A MONTH OOVE 94 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Yea 5 SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS MIN 1 🖳 M 2 🗌 F YRS. 213 03 3044 76 9-19-17 Maryland Page 6 may be retained by the hospital or attending physician. all director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Bayview Hopkins Baltimore na RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Baltimore Co 1 YES 2 NO Dundalk 100. STREET AND NUMBER 7232 Germanhill Road FUNERAL 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 2122 Heritage Meridian Nurs Hm USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yas or No—
If yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 \bigcirc YES 2 \bigcirc IF YES, GIVE WAR OR DATES 42-451 Never Married 2 K Married 2 NO ВУ 1 TYES 2 NO Specify: Specify: 3 Widowed 4 Olvorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refired.) 15. DECEOENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade compi Elementary/Secondary (0-12) College (1-4 or 5+) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) at Walter Hoover Cora Bailey BE notified a 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 9 Mrs Hortense Hoover S. Castle St, Baltimore, MD 21231 pe 20a. METHOD OF DISPOSITION

1 Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must funeral director, 4 X Donation 5 Other (Specify) 21. SIGNATURE OF PUNERAL SERVICE LICENSEER on ald Wade, Dir examiner 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W.Baltimore St, Balto, MD21201 n by the f removal. medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in by Approximate shock, or heart failure. List only one cause on each line. Interval Between ō filled IMMEDIATE CAUSE (Final Onset and Death completely filled the disease or condition 3 wear pheumonia of Right middle lobe resulting in death) traumatic event, OUE TO (OR AS A CONSEQUENCE OF): attending physician and con methicillin resist unknown ant staph, dureus CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury LED TOLL VODOCULAR CO. COPT + other t that initiated events reaulting in death) LAST 6 the atten Inlury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS I signed by the Health and N PERFORMED? AVAILABLE PRIOR TO mell tees, shows any Dettension COMPLETION DF CAUSE OF GEATH? 1 TES 2 PNO 1 YES 2 NO been : CIAN has by Dept 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) certificate h ftem HOSPITAL:
1 Mpatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 NO PHYSI 4 Nursing Homa 5 Realdence 8 Other (Specify) 6 the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. OEŞCRIBE HOW INJURY OCCURED marked, this (1 Natural 5 Pending Investigation 1 YES 2 NO After the BY 2 Accident 28a. PLACE OF INJURY — At home, farm, straet, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 99 HOSPITAL OR ATTENDI FUNERAL DIRECTOR: A within 72 hours after d COMPLETED 8 Could not be 4 Homicide 28 datarminad Item 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner se stated. (Check only one) TO THE HOSPITAL
TO THE FUNERAL
Be filed within 72 h
IMPORTANT: If I 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 45069 9 qu 9 32 REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

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| PHINCHAL The law requires that the death certific | this perificate has been signed by the attending p | we me State Dept. of Health and Mental Hygien | mind, or item 23 shows any injury, or oth |
| The PHYSIAN: The law requires that the death certific | the thing remiscate has been signed by the attending p | with we the State Dept. of Health and Mental Hygien | merind, or item 23 shows any injury, or oth |
| inner PHRICIAN: The law requires that the death certific | ment this perificate has been signed by the attending p | death was the State Dept. of Health and Mental Hygien | mental, or item 23 shows any injury, or oth |
| This is the carrier that the death certific | The man min permicate has been signed by the attending p | The one of the State Dept. of Health and Mental Hygien | s mental, or item 23 shows any injury, or oth |
| TITLE OF THE CAN. The law requires that the death certific | more and the attending p | The death was the State Dept. of Health and Mental Hygien | 28 menting, or item 23 shows any injury, or oth |
| A ATTENDAGE PHYSICIAN: The law requires that the death certific | PETTO A min remit cate has been signed by the attending p | uns the death was the State Dept. of Health and Mental Hygien | im 28 m merting, or item 23 shows any injury, or oth |
| OR ATTENDAGE PHYSICIAN: The law requires that the death certific | DIRECTION AND THIS DESTRICATE has been signed by the attending p | hours were death was the State Dept. of Health and Mental Hygien | them 25 membrad, or item 23 shows any injury, or oth |
| M. OR WITH DIVISIONAL PHYSICIAN: The law requires that the death certific | AL DIFFERM IN THE CONTROL HAS been signed by the attending p | 72 hours the death with the State Dept. of Health and Mental Hygien | If item 28 membred, or item 23 shows any injury, or oth |
| PITAL OR ATTENDING PHYSICIAN: The law requires that the death certific | IERAL DIRECTOR AND THIS CONTICATE has been signed by the attending p | on 72 hours then death was the State Dept. of Health and Mental Hygien | IT: If them 28 he merting, or item 23 shows any injury, or oth |
| DEPTAL OR ATTENDING PHYSICIAN: The law requires that the death certific | UNERFAL DIRECTION AND THIS CONTINUES BOOM Signed by the attending p | within 72 hours then death was the State Dept. of Health and Mental Hygien | ANT: If them 25 is marked, or item 23 shows any injury, or oth |
| E HISPITAL OR ATTENDING PHINICIAN: The law requires that the death certific | E FUNERAL DIRECTOR CONTROL TO THE PROPERTY DEED SIGNED by the attending p | I within 72 hours ther death with the State Dept. of Health and Mental Hygien | RTANT: II Item 28 members, or Item 23 shows any Injury, or oth |
| THE HISPITAL OR ATTENDING PHINICIAN: The law requires that the death certific | THE FUNERAL DIRECTOR AND THE PURICATE has been signed by the attending p | fied without 72 hours then death was the State Dept. of Health and Mental Hygien | PORTANT: If them 28 members, or Item 23 shows any Injury, or oth |
| TO THE MOSFITML OR ATTRIBUTED HIS TOWN. The law requires that the death certificate be executed within alours after death. Page 6 may be retained by the hospital or | TO THE PLINEMAL DIPPETOR AND THIS SETTICATE has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for | he find within 72 hours were death was the Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT II IEM 28 mercial, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | | | | | | | | | | | | 94 | 264 | 14. |
|--------------------|---|--|--------------------------------------|-------------------------------|---|-------------|---------------|-----------|----------------|---------------------|------------------|---|-------------------|---------|
| | FOR 1 - STATE REGISTRAR | STATE OF I | MARYLAND / | DEPAR | ICAT | T OF H | EALTH DEAT | AND F | | HYGIENE REG. NO. | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF | DEATH | | 3 | TIME OF DEA | TH |
| | CARRIE EVELYN | HARRIS | | | | | | | MONTH | DAY | , | YEAR | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. las. | at birthday) | IF UNDE | R 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF | 06 BIRTH | | | | |
| | 251-40-2987 | 1 M 2 F | 87 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, E | Day, Year) | | Country) | | |
| | 99. FACILITY NAME (If not institution, give st | | 07 | 176.20 | OL CIT | | OR LOCATIO | 21 25 25 | 06/2 | 2/0/ | | | | ina |
| œ | | | | | | | | ON OF DE | EATH | | | | | |
| 2 | Stella Maris H | ospice | | | To | WSO | n | | | | Ba] | Ltimo | re | |
| DIRECTOR | 10e. STATE 10b. COUNTY | 1 | | 10c. CIT | Y, TOWN | OR LOCAT | ION | | | | 10d, INSIDE CITY | | | |
| 티 | Maryland Harf | ord | | | | | Edo | ewo | hod | | | 1 | | 1 NO |
| 7 | 10e. STREET AND NUMBER | OL G | | | | 101 | . ZIP CODE | | <u>JOG</u> | | 10g. CIT | | | |
| FUNERAL | 402A Meadowood | Drive | | | | 21040 USA | | | | | | | | |
| Ž | 11. MARITAL STATUS | 12 WAS DECEDEN | NT EVER IN U.S. AR | MED | 13. | WAS DEC | | | VIC ORIGIN? | Specify Year | ~ No- | | American Ind | lien. |
| | 1 Never Married 2 Married | FORCES? 1 | YES 2 XN | 10 | | Il yes, spe | ocity Cubar | n, Mexica | n, Puerlo Ric | an, etc.) | | | | |
| B | 3 Widowed 4XXDivorced | " ', | WIN ON DAILS | | | 1 120 | ZA NO | apouny | у: | | | Specny. | White | |
| | 15. DECEDENT'S EDUC (Specify only highest grade | CATION | | CEDENT'S | | | | | 16b. K | IND OF BUSI | NESS/INC | | | |
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| FL | 9th | | | tres | S | | | | Res | staur | ant | Bus | iness | |
| COMPLETED | 17, FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTH | HER'S NA | ME (First, Mid | | | | 111001 | |
| BE C | Arthur Fr | anklin | | | | | | | LaTi | shia | Wal | lin_ | | |
| | 19e, INFORMANT'S NAME (Type/Print) | | 198 | b. MAILING | ADDRES | S (Street a | nd Number | _ | Route Number, | | | | | |
| 2 | Donna Dennison | | | | | | | | | | | | d MD | 2104 |
| | 20e. METHOD OF DISPOSITION 1 Duriet 2 A Cremetion 3 Remo | | 20b. PLACE A | ANDDATE | OF DISPOS | SITION /Ne | me of | | DATE | 20c. LOC | ATION - | City or Town | State | 21040 |
| | 1 Buriet 2 A Cremetion 3 Rame 4 Donation 5 Other (Specify) | oval from State | Metro | matery or o | ther plece) | orv | Tn | | 09/0 | 7 Ra1 | tim | oro | MD | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | 7 | | 22. | NAME AN | ID ADDRES | SS OF FA | CILITY | | | | | |
| | + WINDLY. | Moro | nald | | | | | | | | | | | |
| | Dawn F. McD | onald | | | 29 | 9 F | <u>rede</u> | ric | k Rd | .Balt | imo | re. | | |
| | 23. PART i. Enter the diseases, or o shock, or heart fellure. | complications the List only one car | at coused the de use on each line | eath. Do r | not enter | r the mo- | de of dyl | ng, suci | h ss cardie | c or respin | atory sr | rest, | | |
| | iMMEDIATE CAUSE (Finel disease or condition | 0400 | . 11 - 0 | 0.0 | ^ . | ~ | . / . | | | | | | | |
| | resulting in death) | CITEU | NICH | ENI | NAL FAILURE NOGE OFF: ONGESTIVE HEART FAILURE | | | | | | | | | |
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| NO | Sequentially list conditions, | | | | | ST /1 | 压厂 | 16/ | HET T | THIL | -UE | E | | |
| ¥Ţ. | if sny, leading to immediate cause. Enter UNDERLYING | DUE TO | OR AS A CONSEC | DUENCE O | F): | | | | | | | | | |
| 2 | CAUSE (Disesse or Injury | C. DUE TO | 100 40 4 00MBE | | | | | | | | | | - | |
| ERTIFICATION | that initiated events resulting in death) LAST | DUE TO | OR AS A CONSEC | DUENCE O | F): | | | | | | | | | |
| CER | | d | | | | | | | | | | | - | |
| | PART ii, Other significant condition | s contributing to | death but not r | reaulting | in the u | nderlyln | ceuse g | given in | Part i. 2 | 4a. WAS AN A | | | | |
| 5 | | | | | | | | | | PERFORM | 1 | 0 | COMPLETION OF | |
| E | | | | | | | | | — I. | YES 2 | NO | 1 6 | | *** |
| PHYSICIAN: MEDICAL | DID TOBACCO USE | CONTRIBUT | F TO CAU | SE OF | DEA | TH Y | 'ES X | I NO | | | | ' | YES 2 | NO |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | . 10 0.10. | | | | 7 | | eck only one) | | | | | |
| SIC | EXAMINER? 1 YES 2 XNO | HOSPITAL: | ☐ ER/Outpetient 3 | □ DO A | OTHE | R: | | | | . 11. | | | | |
| HX | 27. MANNER OF DEATH | 26e. DATE OF | | 26b. TIM | | 28c. INJ | | aldenca | 6 X Other (S | Specify) H(| | | | |
| | 1 Netural 5 Pending | (Month, E | Day, Year) | | JURY | WO | RK? | ¬ NO | | | | | | |
| B | 2 Accident Investigation 3 Suicide & Could not be | 26e. PLACE (| OF INJURY — At ho | me. ferm. | street, fec | | | | 281. LOCAT | ION (Street ar | ad Numbe | or Rural Box | in Alimber | |
| ED | 4 Homicide 8 Could not be | building | , atc. (Specify) | 1114, 1, | mirmory | nory, orner | | | | Town, State) | IQ IVIIII | BUSINESS 11 In Zip Code) degewood, MD 21040 City or Town, State more, MD ryland, Inc. ore, MD 21228 Approximate Interval Between Onset and Death y 24b. Were Autopsy Findings Amarable Prior to Completion of Cause Df Death? 1 yes 2 □ No 11 in 2 Interval Between Onset and Death | | |
| COMPLETED | 29e. CERTIFIER | | | | | | | | | | | | _ | |
| NP. | (Check only | CIAN: To the best of | | | | | | | | | | | | |
| 8 | 2 MEDICAL EXAMINE | R: On the basis of a | examination and/or i | Investigation | эп, In my | opinion, d | eath occur | ed at the | time, data ar | nd place, and | due to ti | he cause(s) s | ind menner as | stated. |
| w I | 296. SIGNATURE AND TITLE OF CERTIFIER | | 1. | | | | 29c. LICE | ENSE NUN | MBER | | 29d. DAT | TE SIGNED (N | Aonth, Day, Year, |) |
| OB | Kendale 2 Facultueums 10 25643 1 9/7/94 | | | | | | | | | | | | | |
| | 30 NAME AND ADDRESS OF PERSON WHI | O COMPLETED ON | ICE OF DEATH ATE | 24 000 00 | O-f-d | | | | | | | | - | |

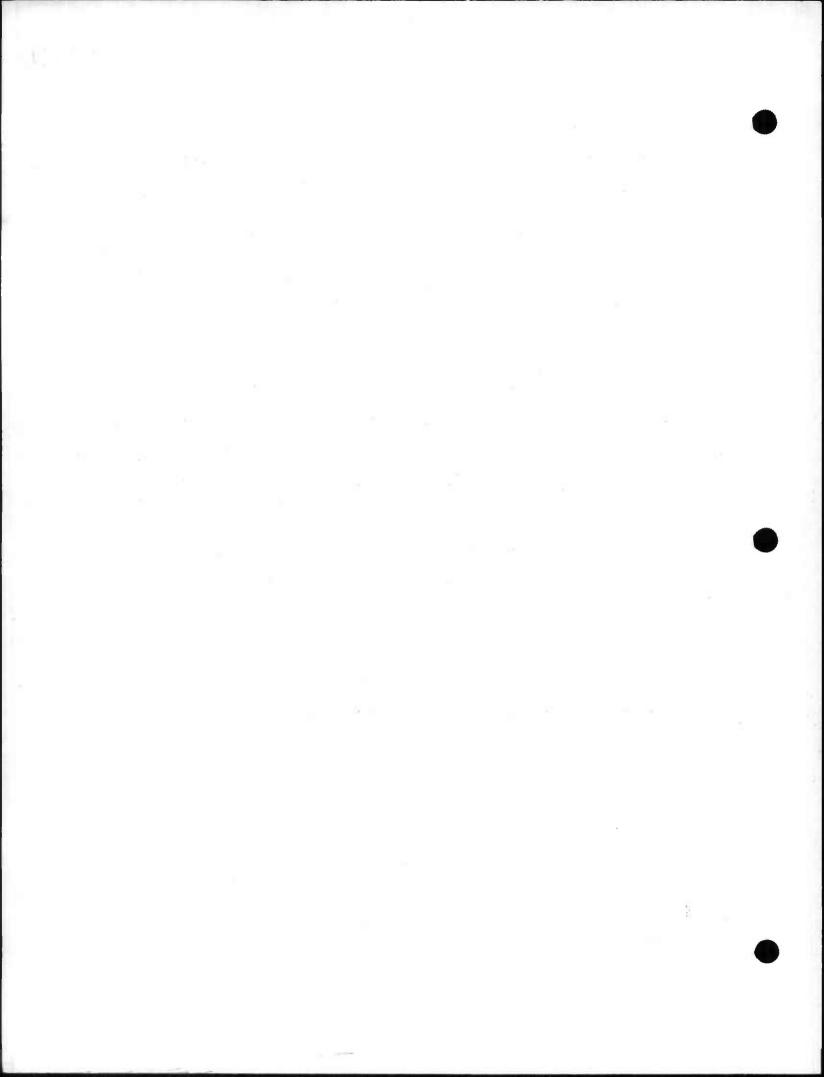
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE ELES (MOTTO 1994

KENDALL FAULKNER, MD 2300 DULANEY VALLEY RD., TOWSON, MD

DHMH-16 Rev 1/89

21204



| | FOR 1 - STATE REGISTRAR | STATE OF | | | | | EALTH DEAT | | MENTAL HYGIE | | 94 | 26415 |
|---------------|--|------------------------|--------------------------------------|-----------|---------------|-------------|----------------------|-----------|---|---------------|--------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF DEATH | DAY | WEAD | 3. TIME OF DEATH |
| | June Ann He | SS | | | | | | | Sept. 4,1 | 994 | YEAR | 10:58 A.M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (In yrs. last | birthday) | | 1 YEAR | IF UNDER | | 7. DATE OF BIRTH | | 6. BIRT | HPLACE (State or Foreign |
| | 219-32-9985 | 1 M 2 F | 58 | YRS. | MONTHS | DAYS | HOURS | MIPI. | June 11,1 | 936 | Coun | ryland |
| | 9a. FACILITY NAME (If not institution, give | street and number) | | | 9b. CIT | Y, TOWN | OR LOCATE | ON OF D | | | UNTY OF | - |
| TOR | 5211 Staab Terra | ice | | | | Bal | timo | re | City | | N/A | |
| DIRECTOR | Md. 106. COUNT | - | | | y, rown | | City | 7 | | | | 10d. INSIDE CITY LIMITS? 12 YES 2 NO |
| | 10e. STREET AND NUMBER | | | | 1011 | | f. ZIP COD | | | 10a C | TIZEN OF | WHAT COUNTRY? |
| FUNERAL | 5211 Staab Ter | race | | | | | | 2120 | 16 | | J.S.A | |
| N | 11. MARITAL STATUS | | NT EVER IN U.S. ARI | uen. | 12 | WHE DE | | | NIC ORIGIN? (Specify | | | - |
| B | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? | 1 YES 2 N WAR OR DATES | | 13. | If yes, sp | ecity Cubi | ın, Maxic | an, Puerto Rican, etc.) | WE OF NO | Spec | E — American Indian, ik, Whita, atc. by: White |
| 8 | 15. DECEOENT'S EDI (Specify only highest grad | JCATION Completed | 16a. OE | CEOENT'S | USUAL C | CCUPATI | ON ost of working | | 16b. KIND OF E | USINESS/II | NDUSTRY | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5 | . Ille | Do NOT u | se retired.) | aunng me | SE OF WORK! | ng | | | | |
| . 교 | 8th Grade | | Cu | stod | ian | | | | Marylan | d Nat | tiona | 1 Bank |
| | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOT | HER'S N | AME (First, Middle, Maid | | | |
| | Urban Louis | Davis | | | | | | Anna | a Kestler | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 196 | MAILING | ADDRES | S (Street | | | Route Number, City or T | | Zio Code) | |
| 2 | Gregory U. Evans | | | | | | | | | | | 1838 |
| 5 | Gregory U. Evans 4941 Tulls Corner Rd. Marion, Maryland 21838 20a, METHOD OF DISPOSITION 20b, PLACE AND DATE OF DISPOSITION (Name of Date 20c, LOCATION — City or Town, Steta | | | | | | | | | | | |
| in in | 1 B Burlai 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) Parkwood Cemetery 9/7 Baltimore, Maryland | | | | | | | | | | | |
| 5 | 21, SIGNATURE OF FUNERAL SERVICE L | CENSEE | Talkw | oou | | | ND AOORE | SS OF E | 7 7 . | | | |
| | 1/ | 11 | 0 | | | | | | U | | | r Road |
| Z Z | Bathlen | M' Mu | yokes/ | | ho | nn (| . M1 | ттет | c, Inc. B | artin | nore, | Md21206 |
| | 23. PART I. Entar the diseases, or | complications th | at caused the de- | ath. Do | not ente | r the mo | de of dy | ing, su | ch as cardiac or res | piratory a | rreat, | Approximata |
| | hock, or heart failure. | List only one ca | use on each line. | | | | | | | | | Interval Between Onset and Death |
| 2 | disease or condition | (- | MILES | | | HE | AR- | | FAIL | URF | = | Onset and oscali |
| | resulting in death) | a. CO | NGEST | HENCE O | ₽ | 111 | 111- | • | • | | _ | |
| 8 | | | | AD | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, | b. DUE TO | O (OR AS A CONSEC | | | | | | | | | |
| A | if any, lesding to immediate cause. Enter UNDERLYING | | MOKI | | * | | | | | | | |
| | CAUSE (Disease or injury | W | O (OR AS A CONSEC | | | | | | | | | |
| Ē | that initiated events reaulting in death) LAST | | , | | . ,, | | | | | | | |
| | | d | | | | | | | | | | |
| 5 - | PART ii. Other significant condition | | | | | | g cause | given ir | | AN AUTOPS | Y 24 | b. WERE AUTOPSY FINDINGS |
| MEDICAL | MAN | 16- | DEPRE | 22 | ION | 1 | | | PERF | ORMED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | | | | | 2 1/10 | | OF DEATH? |
| X | | | | | | | | - | | | | 1 TES 2 NO |
| PHYSICIAN: | OF WAS CASE DEFENDED TO MEDION | | | | | | | | | | | |
| 5 5 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHE | | LACE OF D | DEATH (C | heck only one) | | | |
| YS | 1 TYES 2 THO | | ☐ ER/Outpetlant 3 | | 4 🗆 Nu | rsing Hon | 10 5 R | asidence | 8 Other (Specify) | | | |
| E E | 27. MANNER OF DEATH | 28a. DATE O (Month, | F INJURY Day, Year) | 285. TIR | IE OF JURY | | JURY AT DRK? | | 28d. DESCRIBE HOV | V INJURY O | CCURED | |
| B | 1 Natural 5 Pending 2 Accident Investigation | | | | M | 1 🗆 | YES 2 | NO | | | | |
| | 3 Suicide 6 Could not be | 28a. PLACE building | OF INJURY At hor , atc. (Specify) | me, farm, | street, fac | tory, offic | :0 | | 28f, LOCATION (Stree City or Town, Sta | | per or Rural | Route Number, |
| TE | 4 Homicide determined | | | | | | | | , | | | |
| COMPLETED | 29a. CERTIFIER 1 CERTIFYING PHYS | BICIAN: To the best of | of my knowledge, de | eth occur | ed at the | time, data | and place | , and du | e to the cause(s) and n | Nelliner as = | tated. | |
| - X | | | | | | | | | | | | (a) and menner as stated. |
| _ | 296, SIGNATURE AND TITLE OF CERMIN | 10 4 | | | | e e l | | | | | | |
| | SOURCE AND THE OF CHAPTER | Julel | n | 2 | 0 | | | ENSE NU | 000 8 | 29d. D/ | TE SIGNE | D (Manth, Day, Year) |
| E o | 1110 | HO COMPLETED CAL | _ " | | ٧. | | P | 70 | 000 | | 1/6 | 174 |

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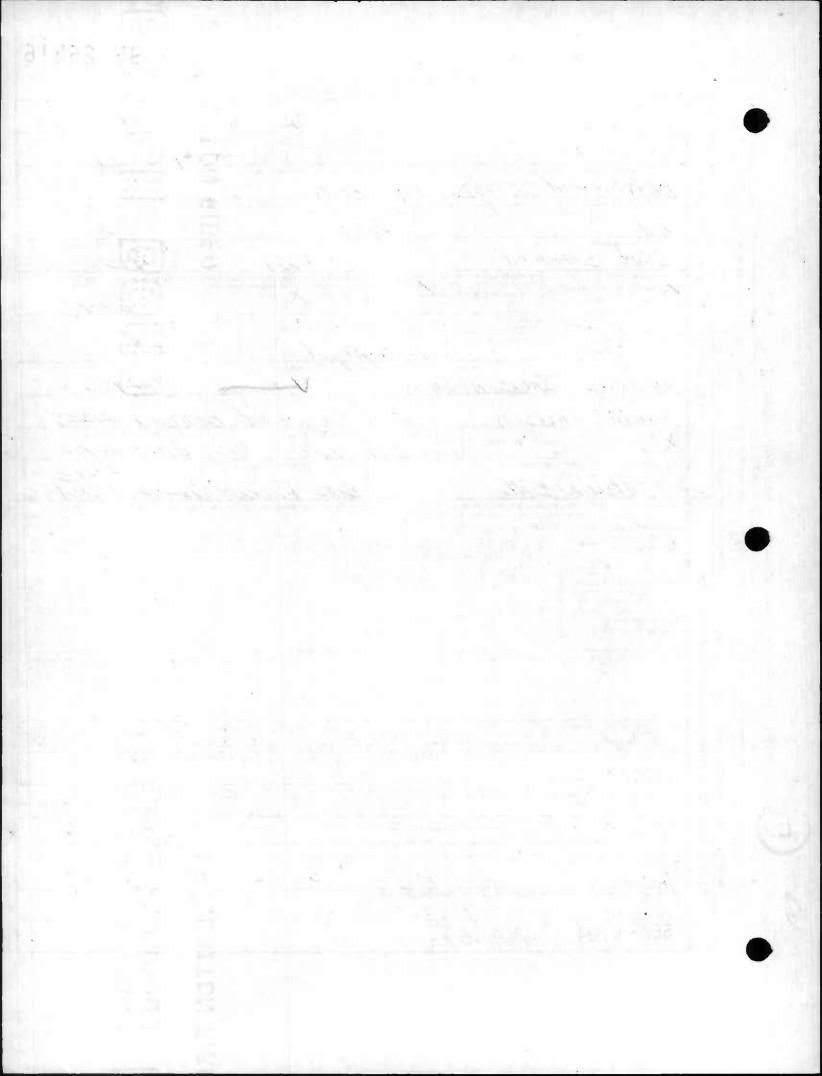
32 AEGISTHATS SIGNATURA

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31. DATE FILED (Month, Day, Year)
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BALTIMORE

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| PROPERTY NAME (FOR INDIRECTOR OF DEATH AND AND AND COCCURRED TO THE AND AND AND AND AND AND AND AND AND AND | E OF DEATH |
| THE STATE STATUS SOLUTION SOlution So | (State or Forei |
| 11. MARINE STATUS 12. WAS DECEMBENT SENDATION 13. WAS DECEMBENT SENDATION 14. BACKET STATUS 12. WAS AN AUTOPSY 17. B 2 MO 1 | NSIDE CITY IMITS? YES 2 NO |
| TOTAL TOTAL STATE CAUSE (Final disease, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arreat. In Interest Cause (Final Membra), that conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death of my store and part is part of the time, data and place, and due to the cause(i) and memore as stated. PART III. Other significant conditions caused the death countered at the time, data and place, and due to the cause(i) and memore as stated. | DUNTRY? |
| TO THE STAND OF BUSINESSINDUSTRY 100. MALING ADDRESS (Storet and Number or Paral Rules Number, City or Rown, State 2014) 11. FATHER'S NAME (First, Middin, Last) 12. MALING ADDRESS (Storet and Number or Rural Rules Number, City or Rown, State 2014) 12. SIGNATURE AND STANDAM (Typoshring) 130. PLACE AND DATE OF DISPOSITION (Remord) 12. SIGNATURE AND ADDRESS (Storet and Number or Rural Rules Number, City or Rown, State 2014) 12. SIGNATURE AND ADDRESS (Storet and Number or Rural Rules Number, City or Rown, State 2014) 12. SIGNATURE AND ADDRESS (Storet and Number or Rural Rules Number, City or Rown, State 2014) 12. SIGNATURE AND ADDRESS (Storet and Number or Rural Rules Number, City or Rown, State 2014) 12. SIGNATURE AND ADDRESS (Storet and Number or Rural Rules Number, City or Rown, State 2014) 12. SIGNATURE AND ADDRESS (Storet and Number or Rural Rules Number, City or Rown, State 2014) 12. SIGNATURE AND ADDRESS (Storet and Number or Rural Rules Number, City or Rown, State 2014) 12. SIGNATURE AND ADDRESS (Storet and Number or Rural Rules Number, City or Rown, State 2014) 12. SIGNATURE AND ADDRESS (Storet and Number or Rural Rules Number, City or Rown, State 2014) 12. SIGNATURE AND ADDRESS (Storet and Number or Rural Rules Number, City or Rown, State 2014) 12. SIGNATURE AND ADDRESS (Storet and Number or Rural Rules Number, City or Rown, State 2014) 12. SIGNATURE AND ADDRESS (Storet and Number or Rural Rules Number, City or Rown, State 2014) 12. SIGNATURE AND ADDRESS (Storet and Number or Rural Rules Number, City or Rown, State 2014) 12. SIGNATURE AND ADDRESS (Storet and Number or Rural Rules Number, City or Rown, State 2014) 12. SIGNATURE AND ADDRESS (Rown, State) 12. SIGNATURE AND ADDRESS (Rown, State) 13. Signature And State 2014 (State 2014) 14. Signature And State 2014 (State 2014) 15. Signature And State 2014 (State 2014) 16. Signature And Address (State 2014) 16. Signature And Address (State 2014) 17. FATAL Rules And ADDRESS (Rown, State 2014) 18. Signature And Address (State 2014) | erican Indian, |
| The malling list conditions and the state of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acceptable of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acceptable of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acceptable of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acceptable of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acceptable of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acceptable of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acceptable of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acceptable of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acceptable of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acceptable of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acceptable of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acceptable of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acceptable of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acceptable of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acceptable of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acceptable of the significant | 1 |
| 20. PLACE AND DATE OF DISPOSITION 20. PLACE AND DATE OF DISPOSITION Name of 20. PLACE AND DATE OF DISPOSITION Name of 20. PLACE AND DATE OF DISPOSITION Name of 20. PLACE AND DATE OF DISPOSITION Name of 20. PLACE AND DATE OF DISPOSITION Name of 20. PLACE AND DATE OF DISPOSITION Name of 20. PLACE OF DEATH 20. PLACE OF | |
| The control Comment | |
| 23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest. Annual | in / |
| NOTED TO Sequentially list conditions and in the interval of the season of the interval of the season of the interval of the season of the interval of the season of the interval of the season of the interval of the season of the interval of the season of the interval of the season of the interval of the season of the interval of the season of the interval of the season of the interval of the season of the interval of the inter | 13 |
| PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be detarmined 28a. DATE OF INJURY At home, farm, street, factory, offica 29a. CERTIFIER (Check only one) 29a. CERTIFIER (Check only one) 29a. CERTIFIER (Check only one) 29b. State of DEATH (Check only one) 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Vear) 29d. DATE SIGNED (Month, Day, Vear) 29d. DATE SIGNED (Month, Day, Day) 29d. DATE SIGNED (Month, Day, Day) 29d. DATE SIGNED (Month, Day, Day) 29d. DATE SIGNED (Month, Day, Day) 29d. DATE SIGNED (Month, Day, Day) 29d. DATE SIGNED (Month, Day, Day) 29d. DATE SIGNED (Month, Day, Day) 29d. DATE SIGNED (Month, Day, Day) 29d. DATE SIGNED (Month, Day, Day) 29d. DATE SIGNED (Month, Day, Day, Day, Day, Day, Day, Day, Day | Approximatinterval Betronset and I |
| The state of the | BLE PRIOR TO |
| The state of the | |
| 2 Accident 3 Suicide 4 Homicide 8 Could not be detarmined 28e. PLACE OF INJURY — At home, farm, street, factory, office 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29e. LICENSE NUMBER 29d. DATE SIGNED (Month, C. | |
| 296. CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated, (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manual place. The cause of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manual place. The cause of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manual place. The cause of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manual place. The cause of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manual place. | imber, |
| 296. LICENSE NUMBER 29d. DATE SIGNED (Month, L | isnner as sta |
| 1 10 - 00 - 00 0 1 7 - · V · | Day, Year) |
| P NAME AND ADDRESS OF PERSON WHO COMPLETED CHUSE OF DEATH (ITEM 27) (Typa, Print) ADM O DON'T FLO Rutland Ne Balhows MD | /_ |



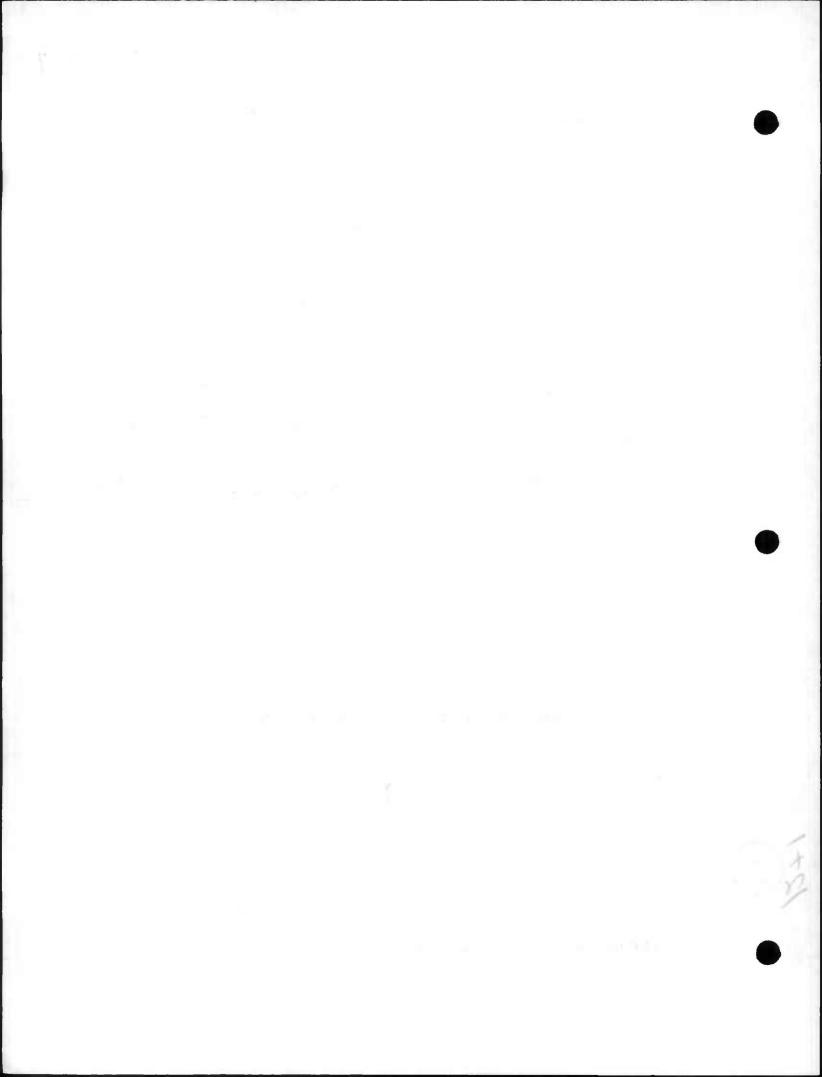
TO THE FAVOR. OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the foath. Page 6 may be retained by the hospital or attending physician.

THE FAVOR. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be attended to use as the buriat-transit permit. Pages 1, 2, 3 should be attended, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

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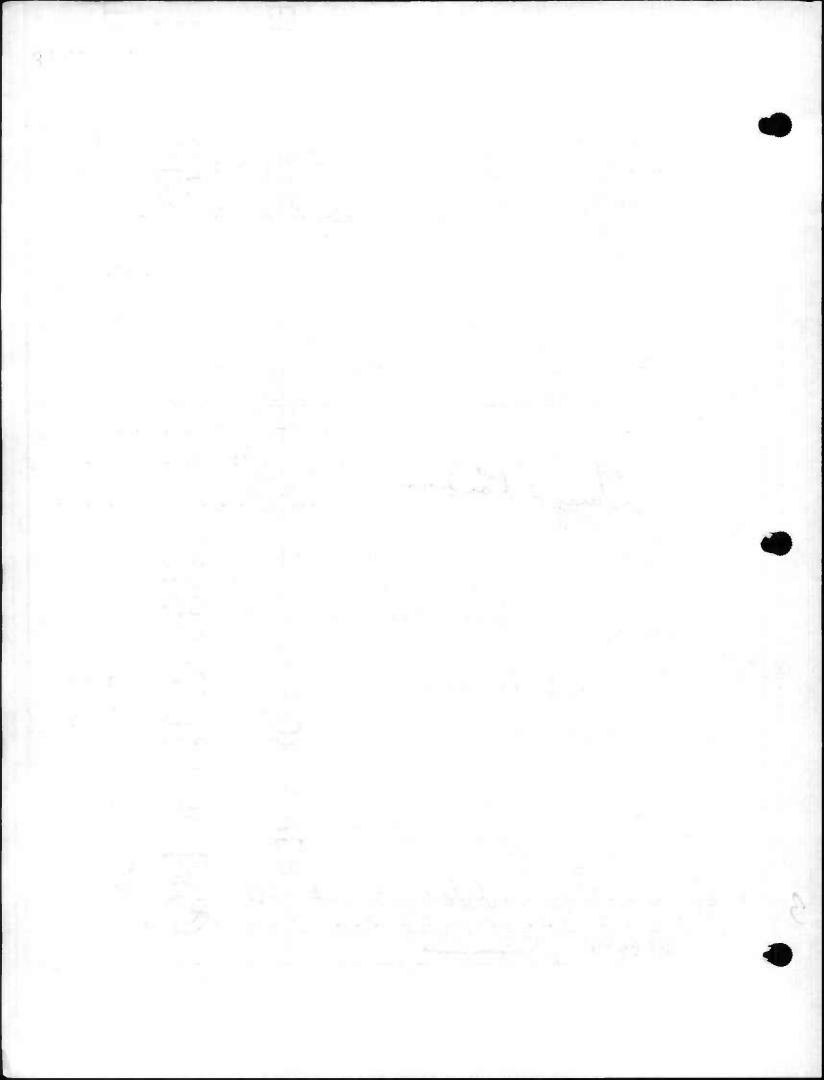
FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CERTIFIC | CATE OF D | DEATH | REG. NO |). | | |
|--|--|--|---------------------------------------|-----------------------|---------------------|--|----------------|-------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | | 3. TIME OF DEATH |
| | VALENTINE | A. KOGLE | RTR. | | | SEPT. 7, | | YEAR | M |
| | 4. SOCIAL SECURITY NUMBER | | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | | PLACE (State or Foreign |
| | The second secon | 1 🔀 M 2 🗆 F | | | OURS MIN. | (Month, Day, Year) | | Countr | PLACE (State or Foreign y) |
| | 219-18-1373 | | UO YHS. | | | 3-27-19: | 26 | MAR | YLAND |
| | 9e. FACILITY NAME (If not institution, give : | treet and number) | | 9b. CITY, TOWN OR | LOCATION OF DEA | ATH | 9c. COUNT | TY OF D | EATH |
| DIRECTOR | 3705 FRANKFORD | AVENUE | | BALTIM | ORE | | | | |
| 5 | RESIDENCE OF DECEDENT | | | 2-12-1 | <u> </u> | | | | |
| 쀭 | 10s. STATE 10b. COUNT | 4 | 10c. CITY, | TOWN OR LOCATION | N | | | | 10d. INSIDE CITY LIMITS? |
| <u>a</u> | MARYLAND | | l BA | LTIMORE | | | | | TY YES 2 NO |
| 7 | 10e. STREET AND NUMBER | | | | IP CODE | | 10o. CITIZ | EN OF V | HAT COUNTRY? |
| 5 | 3705 FRANKFORD | AVENUE | | | 21206 | | | | |
| Z | 11. MARITAL STATUS | | | 1 | | | | U.S | |
| BY FUNERAL | 1 Never Merried 2 Married | 12. WAS DECEDENT EVER FORCES? 1 X YES | S 2 NO | | | IC ORIGIN? (Specify Yes, Puerto Rican, etc.) | a or No— | 14. RACE Black | — American Indian, , White, etc. |
| ≿ | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR | DATES | 1 YES 2 | NO Specify: | | | Speci | WHITE |
| | | | | | | | | | MUTIE |
| 핃 | 15. DECEDENT'S EDU (Specify only highest grade | completed) | 16a. DECEDENT'S U (Give kind of wo | rk done during most c | of working | 16b. KIND OF BU | SINES\$/INDU | ISTRY | |
| ш. | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use | | | 7.47 | ETI/ODY | | - |
| ₽ | 12 | 4 | LAWY | EK | | BAL | r I MORE | CI | LA |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | 1 | a. MOTHER'S NAM | NE (First, Middle, Maider | Surname) | | |
| m l | VALENTINE A. | KOGLER, S | SR. | | HILDA | A HAIN | | | |
| m | 19a. INFORMANT'S NAME (Type/Print) | TO OMBILL | | DDRESS (Street and | | oute Number, City or Tox | un Otata Yin / | Codel | |
| 2 | BARBARA KOGLER | | 1 | | | | | | 1206 |
| | | | | | | , BALTIMON | | | |
| | 20a. METHOD OF DISPOSITION 1 | oval from State Cr | Ob. PLACE AND DATE OF | | | DATE 20c, LC | CATION — C | ity or To | wn, Stata |
| | 4 Donetion 5 Other (Specify) | | GREEN MOUN | T CREMAT | ORY 9-8- | -94 BAI | LTIMOR | E, | MARYLAND |
| 21. SIGNATURE OF AUNERAL SERVICE LICENSER 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | |
| | > 1200 V | NAT | M00550 | BRADLE | Y-ASHTON | N FUNERAL | HOME, | IN | C. |
| _ | 1 weep | delles | | 2134 W | ILLOW SI | PRING RD. | BALT | 'IMO | RE, MD 21222 |
| | 23. PART I. Enter the diseases, or shock, or heart failure. | complications that cause List only one cause on | ed the death. Do no | t anter tha moda | of dying, such | sa cardiac or reap | iretory arre | at, | Approximata Interval Between |
| - 1 | | | | | | 10 | | | Onset and Daath |
| | disease or condition | DUE TO (OR AS | a Dra | VICE ADI | 1040 | . I Par | CMAS | | IIMOS |
| | resulting in death) | DUE TO (OR AS | A CONSEQUENCE OF | 30 07261 | ~ CITYIF | 4 122 | الاعرط | > | 11 1102 |
| _ | | | | | | | | | |
| 6 | Sequentially list conditions, | b. DUE TO (OR ## | CONSEQUENCE OF | | | | | | |
| F | if any, leading to immediata cause, Enter UNDERLYING | 7 | A CONSESSENCE ON | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury | C. DUE TO COM | A CONSEQUENCE OF | | | | | | |
| ĖΙ | that initiated events reaulting in death) LAST | DUE TO (USE AS | A CONSEQUENCE OF): | | | | | | |
| E | Todatally Exist | d | | | | | | | |
| 0 | PART II. Other significant condition | a contributing to death | hut not possible a la | Ab a see do ab da a a | | | | | |
| DICAL | | | but not remulting in | tha underlying c | ausa given in P | Part I. 24s. WAS AN PERFO | | 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| 8 | | sue | | | | 1 🗆 YES : | NO | - | COMPLETION OF CAUSE OF DEATH? |
| ME | <u> </u> | | | | | ĺ | | 1 | 1 THE TO NO |
| | DID TOBACCO USE | CONTRIBUTE TO | CALISE OF | DEATH VEG | | | | 1 - | |
| A | 25. WAS CASE REFERRED TO MEDICAL | CHIKIBOTE TO | CAUSE OF | | E OF DEATH (Chec | | _ | 1/ | |
| SICIAN: | EXAMINER? | HOSPITAL: | | OTHER: | | | | | |
| ₹ | t Pes 2 No | 1 Inpetient 2 ER/Ou | | Nursing Home | | | | | |
| РНҮ | 27. MANNER OF DEATH 1 Natural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | | | | 28d. DESCRIBE HOW | INJURY OCCI | JRED | |
| BY | 1 Netural 5 Pending 2 Accident Investigation | | - h | M 1 YES | 3 2 NO | 0 | | | |
| | 3 Suicide 8 Could not be | 26a. PLACE OF INJUR building, atc. (Sp | RY - At home, term str | tartory, office | | 281. LOCATION (Street City of Town, State | and Number o | or Rural F | loute Number, |
| E | 4 Homicide detarmined | | | | | City or lown, State | | | |
| COMPLETED | 29a. CERTIFIER | | | | | | | | |
| A P | one) | ICIAN: To the best of my kno | | | | | | | |
| Ö | 2 MEDICAL EXAMINE | R: On the basis of examinat | ion and/or investigation. | In my opinion, deat | h occured at the ti | time, date and place, a | nd due to the | cause(s |) and manner as stated. |
| Ш | 295 SIGNATURE AND TITLE OF CERTIFIE | | | 21 | 9c. LICENSE NUM | BER | 29d. DATE | SIGNED | (Month, Day, Year) |
| 0 | VI. do | 1 | _ | | 17201 | 43 | • | c/ | 9/01/ |
| 유 | 30. NAME AND ADDRESS OF PERSON WITH | O COMPLETED CAUSE OF D | DEATH /ITEM 270 /3 | briest) | 12301 | | | 11 | 9/77 |
| | 2- (0/1 | | | | | | | - 1 | / |
| | -30 St 194 | (see 7 20 | 1070 | W WO | 515 | 02 | | | |
| - 1 | 21. DATE FILED (Mooth, Day, March | 32. REGISTRAR'S SIG | SNATURE | | | | | | |
| | ('1) 1) () | 4 | | | | | | | |
| | SEY U 9 1554 | down is andem- | Rudall | | | | | | |



| DIVISION OF VITAL RECORDS, P.O. BOX 68760, TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the law state death, Page 6 may be retained by the hospital or attending physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that been signed by the entending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be a filled at once. |
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| | FOR 1 - STATE REGISTRAR | STATE OF I | MARYLAN | ID / DEPA | | | | | | HYGIENI REG. NO. | E | | | |
|---|---|--|------------------------|------------------------------|---------------|---------------|--------------|-----------|-------------------------------------|---------------------|------------|-----------|--|--------|
| 1 | 1. DECEDENT'S NAME (First, Middle, | Last) | | | | | | | 2. DATE OF | | v | WEAD | 3. TIME OF DEATI | |
| | CORA E. | KOHLEE | P | | | | | | 09 | O | | YEAR | 4:20 | P |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | | rs. last birthday | | | IF UNDER | | 7. DATE OF | BIRTH Day Mand | | 6. BIRTI- | IPLACE (State or For | reign |
| | 212-14-9174 | 1 M 2XX | 96 | YRS. | MONTHS | DAYS | HOURS | MIN, | 03 | 24 | 98 | | RYLAND | |
| | 9a. FACILITY NAME (If not institution, | give street and number) | | | 9b. CITY | , TOWN | R LOCATIO | ON OF DE | EATH | | 9c. COU | NTY OF D | EATH | |
| CTOR | NORTH ARUND | T | AL | | | GLE | N BU | RNI | E | | AN | NE | ARUNDEI | 1 |
| DIRECTOR | MARYLAND AN | NE ARUNDE | L | 10c. CI | TY, TOWN GL | | ION BURN | IE | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 | NO |
| FUNERAL | 100. STREET AND NUMBER 317 WENDE CO | URT | | | | 101 | 210 | | | | | J.S. | WHAT COUNTRY? A. | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 2 Wildowed 4 Divorced | 12. WAS DECEDED FORCES? IF YES, GIVE | YES | 2 XNO | | If yes, sp | | n, Maxica | NIC ORIGIN? in, Puerto Ric y: | | or No- | Spec | E — American India k, White, atc. #y: TTE | in, |
| 0 | 15. DECEDENT'S | | 10 | Sa. DECEDENT | | | | | 16b. R | IND OF BUS | BINESS/IN | DUSTRY | | |
| Ħ. | (Specify only highest Elementary/Secondary (0-12) | College (1-4 or 5 | +) | (Give kind o life. Do NOT | use retired.) | auring mo | et of workin | ng . | | | | | | |
| Ā | 12 | 0 | | HOUS | EWIF | E | | | | HOME | MAKE | R | 100 | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Las | | | | | | | | ME (First, Mic | | | | | |
| BE | | REIBER | | | | | | RRI | | | TMAN | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | | | Route Number | | | | 21060 | |
| | EVA J. PASC | OE | | | | _ | | (1-6 | | | _ | | 21060 | |
| 20a. METHOD OF DISPOSITION 10 Burlail 2 Cremation 3 Removal from State 11 Donation 5 Other peeclty 20b. PLACE AND DATE OF DISPOSITION (Name Care Place) 20c. LOCATION — City or Town, State Care Place) 20c. PLACE AND DATE OF DISPOSITION (Name Care Place) 20c. LOCATION — City or Town, State Care Place) 20c. BALTIMORE, MD. | | | | | | | | | | | | | | |
| 100 | 21. SIGNATURE OF PARTY SERVICE LIBENSEE 22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY.S.W.GLEN BURNIE, MD. | | | | | | | 51 | | | | | | |
| | 23. PART I. Enter the diseases | , or complications the | et ceused ti | he deeth. Do | not ente | the mo | de of dy | ing, suc | ch ea cardia | ac or respi | Iratory sr | reat, | Approxime | |
| | ahock, or heart fellula. List only one ceuse on each lina. Interval Between Onset and Desti | | | | | | | | | | | | | |
| Z | DUE TO (OR/AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO | (OR AS A C | ONSEQUENCE | OF): | 1000 | 1 | 0 | 0 | 0 11 | 10 | 1 | | |
| 2 | CAUSE (Disease or injury | c. Let | JULY AS A C | ONSEQUENCE | 1010 | erco | u j | m | -cere | 7 00 | 7 | | | |
| THE | that initiated events resulting in death) LAST | DOE IN | O A EA HO) | Card | in l | an | whi. | 1 | Shell | in | | | | |
| CEL | | d | | | | | Leg | | 1,200 | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other algnificant con | and and | death but | not resulting | in the u | nderlyin | g ceuse | given in | 11 | PERFOR | RMED? | 241 | b. WERE AUTOPSY FI AVAILABLE PRIOR COMPLETION OF C | TO |
| 밀 | | | | | | - | | | | | ALL. | | OF DEATH? | NO |
| 2 | | | | | | | | - | _ | | | | N/A | |
| X | 25. WAS CASE REFERRED TO MEDIC | | | | | | LACE OF D | DEATN (C | heck only one, |) | | | | |
| SIC | EXAMINER? | HOSPITAL: | ☐ ER/Outpati | lent 3 🗆 DOA | OTHE | | ne 5 🗆 Re | esidence | 5 🗆 Other | (Specify) | | | | |
| H | 27. MANNER OF DEATN | 28a. DATE O | F INJURY Day, Year) | | IME OF | | JURY AT | - | 28d. DE\$C | RIBE HOW I | INJURY O | CURED | | |
| BY | Netural 5 Pending Accident Investige | 3 1 | | | M | | YES 2 | NO | | - 1 | 77 | | | |
| 1 281, PLACE OF INJUNY — AI DOME, TRIM, STREET, TRICTORY, OFFICE 1 281, LOCATION (Street and Number of Pural Point Number | | | | | | Route Number, | | | | | | | | |
| COMPLETED | (Oraca only | PHYSICIAN: To the best of | | | | | | | | | | | (a) and menner as s | tated. |
| | 29b. SIGNATURE AND TITLE OF CE | RTIFIER 1 | 11 | | | | 29c. LIC | ENSE NU | MBER | - | 29d, DA | TE SIGNE | D (Month, Day, Year) | |
| BE | Jan | P/K -1 | 17 | 27 / | in | | D | 171 | 94 | | | | 8/94 | |
| 5 | 30. NAME AND ADDRESS OF PERSONS ANG K. HAN | / | / | H (ITEM 27) (T) AIN H | | TAT | #406 | -CT | EN P | IIBMT | | • | | |
| | | | AR'S SIGNAT | | 14 T P | . ** . | W-100 | , G1 | TTA D | OIGAT. | r , Pil | . 2 | 1001 | |
| | SEP 0 9 1994 | (1) | en-Ra | | | | | | | | | | | |



68760, BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within chours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit pobe filed within 72 hours after death with the State Dept. of Health and Mental Hypiene prior to burial, cremation, or removal. | IMPORTANT If Item 20 is marked as item 22 shaues and inliner as other featured as another accompany and the mailing as a mark |
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| | 1 - FOR STATE OF MARYLAND / DEPARTMENT OF REGISTRAR CERTIFICATE OF | |
|-----------|--|---|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH |
| | KAYLA NICOLE KERSEY | SEPT. 05,1994 18:40 P M |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEA | 44 |
| | 1 M 2LXF L YRS. | Dec.17,1992 Maryland |
| - | 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOW | N OR LOCATION OF DEATH 9c. COUNTY OF DEATH |
| DIRECTOR | FRANKLIN SOUARE HOSPITAL RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LO | Rossville BALTIMORE |
| | Md. Baltimore | Parkville 10d. INSIDE CITY LIMITS? |
| \¥ | 10e. STREET AND NUMBER | 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? |
| FUNERAL | 7918 Belridge Road | 21236 USA |
| 5 | TCRF Never Married 2 Married FORCES? 1 YES 2 NO If yes. | DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— specify Cuban, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Black, Whita, etc. |
| B | | YES 2 NO Specify: Specify: |
| | 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUP | White |
| E | (Specify only highest grade completed) (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) | most of working |
| . 로 | n/a n/a | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Lest) | 16. MOTHER'S NAME (First, Middle, Maiden Surname) |
| 111 | Jason Edward Kersey | Stephanie M. Warren |
| TO BE | | et and Number or Rural Route Number, City or Town, State, Zip Code) |
| | Jason & Stephanie Kersey 7918 Belr | idge Road Baltimore Md. 21236 |
| | 206. METHOD OF DISPOSITION 206. PLACE AND DATE OF DISPOSITION | (Neme of DATE 20c. LOCATION — City or Town, State |
| | | tery 9/8/94 Baltimore Md. |
| a crain | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME | AND ADDRESS OF FACILITY |
| N N | | nelly Funeral HOme of Essex |
| | 23. PART I. Enter the diseases, or complications that caused the disease not enter the | Mace Ave. Baltimore Md. 21221 mode of dying, such as cerdiac or respiretory arrest, Approximate |
| | shock, or heart fellure. List only one ceuse on each line. | Interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | Onset end Death |
| | e. DUE TO (OR AS A CONSEDUENCE OF): | |
| | | į į |
| 2 | Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | |
| 3 | ceuse. Enter UNDERLYING CAUSE (Disease or Injury | |
| THE | that initiated evente DUE TO (OR AS A CONSEQUENCE OF): | |
| 5 1 | resulting in deeth) LAST | |
| | PART II. Other significant conditions contributing to death but not resulting in the underly | ring ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS |
| | | PERFORMED? AMALABLE PRIOR TO COMPLETION OF CAUSE |
| | | 1 VES 2 NO OF DEATH? |
| : MEDIC | DID TORACCO HEE CONTRIBUTE TO CALICE OF DEATH. VEC. TO NO. | T UNICEDANA TO THE 2 NO |
| A N | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 26. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATH /Check only o | |
| 2 | EXAMINER? HOSPITAL: OTHER: | |
| H | A state of the sta | ome 5 Residence 6 Other (Specify) NJURY AT 28d. DESCRIBE HOW INJURY OCCURED |
| | 1 Netural 5 Pending (Month, Day, Year) INJURY | WORK? |
| | 2 Accident investigation 26s. PLACE OF INJURY — At home, farm, streat, factory, o | A surfect thrownes |
| | 4 Homicide determined building, etc. (Specify) | 692 Olymper Exter Arive County |
| E | 29a. CERTIFIER 1 CERTIFYING PHYSICIAN. To the head of the bound of the | |
| | (Check only one) 25 MEDICAL EXAMINER: On the bast of my knowledge, death occurred at the time, done) | ate and place, and due to the cause(a) and manner as stated. It death occured at the time, data and place, and due to the cause(a) and manner as stated. |
| - 1 | 29b. SIGNATUR® AND TITLE OF CERTIFIER | |
| | There I N i | 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | OCME SEPT. 06,1994 |
| | The side of | not political v |
| 1 1 | | eet, Baltimore, Maryland 21201 |
| | SEP 0 9 1994 | |

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attending physician.

by the funeral director, page 5 should be detached for use as the burial-transit removal.

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| | TO THE HOSPITAL OR ATTAINING PHYSICIAN: The law requires that the death certificate be executed within Jours a | TO THE FUNERAL DIRECT A TOTAL COMPLETE HAS been signed by the attending physician and completely filled in by | be filed within 72 hours are dean early the State Oept, of Health and Mental Hygiene prior to burial, cremation, or ren | IMPORTANT: If Item 28 per per an Item 23 shows any Injury, or other traumatic event, the medi- |
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| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | cute | o pu | Duria | tic |
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94 26420 Item1, Film715 9/9/94.1t 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) JOSHUA 2. DATE OF DEATH 3. TIME OF DEATH TALBOTT KELLEY YEAR 9:50 Pm **JOSHUA** KELLEY SEPTEMBER 994 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Formar IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH HOURS 1 🕅 M 2 🗌 F 75 218-07-1011 YRS Oct. 28, 918 Maryland 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH DIRECTOR Greater Baltimore Medical Center Baltimore Towson RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 19c. CITY TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Towson 1 YES 2 NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21204 200 E. Susquehanna Avenue USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. It yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Merried BY Specify: 3 X Widowed 4 Divorced White WW II 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Cabinet Remodeler Cabinet Construction once. 17. FATNER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ William Franklin Kelley Alma Lucille Gemmill BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Alma Norris 10 Ivy Hill Court, Cockeysville, MD 21030 pe 20a. METNOD OF DISPOSITION
1 N Burlel 2 Cremetton 3 Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Mays Chapel Ch. Cem. Sept. 9, 1994 Timonium, MD 4 Donathum 5 Dittam (%) 21. SIGNATURE OF PONERAL BERVICE-CICENSED 22. NAME AND ADDRESS OF FACILITY
Lemmon-Mitchell-Wiedefeld, Inc. examiner Lowell M. Lemmon noon 10 W. Padonia Rd., Timonium, MD 21093 medicar 23. PART I. Enter the disease, or complications that caused the deeth. Do not enter tha mode of dying, such as cerdisc or respiratory errest. Approximate shock, or heert fellure. List only one cause on asch line. Interval Between Onset and Death IMMEDIATE CAUSE (Finel the disease or condition___ CARDIAC STANDSTILL resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): INFECTION, DUE TO STRICTURE OF URETHRA CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate SQUAMOUS CELL CARCINOMA cause. Enter UNDERLYING other t CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 0 Injury, PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 ☐ YES 2 ☐ NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO \square PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) tem HOSPITAL: OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Nome 5 Residence 6 Other (Specify) 告 26a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending Investigation 1 YES 2 NO ΒY 2 Accident 26e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 6 Could not be 4 Nomicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE

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26684

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year) SEP - 9 1994

32. REGISTRAR'S SIGNATURE As wilcon Roball

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DIRECTOR:

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30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 REGISTRAR'S SIGNATURE

J. DIXON Hills Mp.

SFP 9 1994

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Wilhelmine Louise Koester SEPT 14941 0130 AM 4. SOCIAL SECURITY HUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign (Month, Day, Year) 6-25-1916 60-0580 1 DM 2 XF 9e. FACILITY HAME (If not institution, give stre 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH UNION MEMORIAL HOSPITAL DIRECTOR BALTO. CITY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY mD BALTO. MD YES 2 NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 1700 MERIDENE DRIVE 21239 USA 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 TYES 2 THO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or Ho-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Puerto Ricen, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 Merried ВY white 3 Widowed 4 Divorced Specify: 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade comple 16b. KIHD OF BUSINESS/INDUSTRY (Spe (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Retirement Home 17. FATHER'S HAME (First, Middle, Last) 18. MOTHER'S HAME (First Middle Maiden Surname) PAUL ALICE FISCHER BE notified 19e. INFORMANT'S HAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6 Anne Sophia Blair 6101 Loch Raven Blvd. Apt.505 Baltimore,MD2123 9 20e. METHOD OF DISPOSITION
1 Suriel 2 X Cremation 3 F
4 Donation 5 Other (Specify) 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Metro Crematory, Inc. 09/08 Baltimore, MD 21. SIGNATIME OF FUNERAL SERVICE LICENSEE examiner 22. HAME AHD ADDRESS OF FACILITY Dawn F. Cremation Society of Maryland, Inc. 299 Frederick Rd.Baltimore. MD 21228 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, Approximate shock, or hasrt fallure. Liet only one ceuse on each line. intarvai Between **Onset and Death** IMMEDIATE CAUSE (Finel the disease or condition resulting in deeth) ISCHEMIC BOWILL 17 Hours event, DUE TO (OR AS A CONSEQUENCE OF): 35 YEARS ATUEXO SCIB ROSIS traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate INPARCTION 612 BoweL cause. Enter UNDERLYING 17 Heurs CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): thet initieted eventa reaulting in deeth) LAST SHOCK 17 Hours 0 Injury, PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO CARDIO MYOPATHY shows any ISCHEMIC COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 HO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Item HOSPITAL: OTHER:
4 Hursing Home 5 Reeld 1 YES 2 NO ex Other (Specify) 1= CU - UNION MEMBELL 1 | Inpetient 2 | ER/Outpetient 3 | DOA 27. MANNER OF DEATH 28e. DATE OF IHJURY 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF 28c. IHJURY AT WORK? marked, 1 Hetural INJURY 1 YES 2 HO BY 2 Accident Investigation 28e. PLACE OF IHJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6/3 6 Could not be 28 4 Homicide LET llem 29e. CERTIFIER (Check only one) CERTIFIED PHYSICIAH: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner ee stated. COMP 2 MEDICAL EXAMIHER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner se stated. 296. SIGNATURE AND TITLE OF CENTIFIER

3501 ST. PAUL ST.

29c. LICEHSE HUMBER

005063



29d. DATE SIGHED (Month, Day, Year)

ES MATTY

BALTIMERE HZ18

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
|---|----------|
| CERTIFICATE OF DEATH | REG. NO. |

| | 1 - STATE REGISTRAR | STATE OF MARYLAND / CE | DEPARTMENT OF H | | NTAL HYGIENE REG. NO. | | |
|---|--|--|---|----------------------------|-------------------------------------|--|----------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | DATE OF DEATH | 3. TIME OF DEATH | |
| | GEORGE | THOMAS LE | E | 1 ' | 8-13-94 | 5:30 | Ам |
| | | SEX 8. AGE (In yrs. last | | | DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) | ign |
| | | X M 2 □ F 5 9 | YRS. MONTHS DAYS | | -3-1935 | Maryland | |
| 1 | 9a. FACILITY NAME (If not institution, give street | and number) | 9b. CITY, TOWN O | R LOCATION OF DEATH | 9c. C | COUNTY OF DEATH | |
| CTOR | 5102 Norwood A | venue | Ва | altimore | _ | | |
| S | 10a. STATE 10b. COUNTY | | 10c. CITY, TOWN OR LOCAT | ION | | tod. INSIDE CITY | - |
| DIREC | Maryland | | Baltimo | re | | LIMITS? | 10 |
| | 10a. STREET AND NUMBER | | | ZIP CODE | 10g. | CITIZEN OF WHAT COUNTRY? | |
| E E | 5102 Norwood Av | enue | - 1 | 21207 | 7 | USA | |
| FUNERAL | 10 | WAS DECEDENT EVER IN U.S. ART FORCES? 1 YES 2 N | | ENDENT OF HISPANIC O | RIGIN? (Specify Yas or No- | | |
| BY B | t Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DATES | | 2 NO Specify: | iarto Hidan, etc.) | Specify: | |
| ED E | 15. DECEDENT'S EDUCATION | ON | | | | Black | |
| ETE | (Specify only highest grade com | pleted) (Gh | CEDENT'S USUAL OCCUPATION We kind of work done during most Do NOT use retired.) | st of working | 16b. KIND OF BUSINESS. | /INDUSTRY | |
| 김 | Elementary/Secondary (0-12) Co | ollege (1-4 or 5+) | | | Micro-F | f 1 m | |
| once. | 17. FATHER'S NAME (First, Middle, Lest) | | | 18. MOTHER'S NAME (F | First, Middle, Maiden Surnam | The second secon | \dashv |
| E C | Charles H. Lee | | | Anna Del | 1 Hebb | | |
| Hed D B | 19a. INFORMANT'S NAME (Type/Print) | | . MAILING ADDRESS (Street a | | | , Zip Code) | |
| 10 10 | John Lee | | 5102 Norwo | od Avenu | e, Balto, | MD21207 | |
| at D | 20a. METHDD OF DISPOSITION | | ND DATE OF DISPOSITION (Na natory or other place) | me of | DATE 20c. LOCATION | I — City or Town, Stata | |
| E | 4 M Donation 5 Other (Specify) | | | | | | i |
| nlne | 21. SIGNATURE OF TUNERAL SERVICE LICENS | 1 | 22. NAME AN | D ADDRESS OF FACILIT | State Ar | natomy Board | |
| EX | Inans All | ale | 655 | W.Baltimo | | lto,MD21201 | |
| or other traumatic event, the medical examiner must be notified at once. ERTIFICATION TO BE COM | IMMEDIATE CAUSE (Final | Dnly Dne cause Dn each line. | | de of dying, such es | cerdlec or respiratory | Approximete interval Bett Onset and D | ween |
| event, | resulting in deeth) a | DUE TO (OR AS A CONSEQ | | rts) | D | | |
| on aft | Sequentielly list conditions, | DUE TO (OR AS A CONSEO | IVE HE | ARI | FAILUR | E | |
| or other traumatic | If sny, fesding to immediate ceuse. Enter UNDERLYING | | ENSION | | | | |
| 필은 | CAUSE (Disesse Dr Injury that initiated events | DOE TO (OR AS A CONSEO | UENCE OF): | | | | |
| Pr of | resulting in deeth) LAST | | | | | | ı |
| ₹ Ö | PART II. Other significent conditions co | noteibution to death but | andeles le de maria | | | | 1000 |
| | NF-PILOOT | TIC CYN | JAROM | ceuse given in Part | PERFORMED? | AVAILABLE PRIOR TO | 0 |
| ws any EDIC | 11211101 | 10 311 | 145110110 | | 1 TYES 3 NO | OF DEATH? |) SE |
| 2 ≥ | | | | | | 1 TYES 2 NO | , |
| 23 A N | 25. WAS CASE REFERRED TO MEDICAL | | 26 81 | ACE OF DEATH (Check o | raty one) | | |
| SICI/ | EXAMINER? | OSPITAL: Inpetiant 2 ER/Outpetiant 3 | OTHER: | | | | |
| | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIME OF 28c. INJ | e 5 Rasidenca 6 URY AT 28d | J. DESCRIBE HOW INJURY | OCCURED | \dashv |
| | 1 Netural 5 Pending | (Month, Day, Year) | INJURY WO | RK? /ES 2 NO | | | |
| Is mar D BY | 2 Accident Investigation 3 Suicide 8 Could not be | 28a. PLACE OF INJURY — At hor | ne, farm, street, factory, office | 281 | LOCATION (Street and Num | nber or Rural Route Number, | \dashv |
| 20世 | 4 Homicide datarmined | building, atc. (Specify) | | | City or Town, State) | | |
| PL F | 29a. CERTIFIER (Check only t CERTIFYING PHYSICIAN | : To the best of my knowledge, dea | ith occurred at the time, data | and place, and due to th | ne cause(a) and manner as | atated. | |
| ANT: If ite | | n the basis of exemination and/or is | | | | | ted. |
| RTA | 29b. SIGNATURE AND TITLE OF SERVIFIER | D., | -4. | 29c. LICENSE NUMBER | | DATE SIGNED (Month, Day, Year) | \dashv |
| IMPORTANT: If item O BE COMPLE | F8 DI | - PH | SICIAN | D268 | | 8.18.94 | . |
| 일 | 30. NAME AND ADDRESS OF PERSON WHO CO | MPLETED CAUSE OF DEATH (ITEN | 27) (Type, Print) | 926 W | North Av | enue 21217 | |
| | DR KOFI SHAW-T | AYLOR Ma | dison Park | Proffes | ional Bld | enue,21217 g, | |
| | SEP - 9 1994 | 32 REGISTRAR'S SIGNATURE | | | | | |
| | SEP - 9 1994 | This Shudeon Ren | all | | | | |

| DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Nurs after death. Page 6 may be retained by the hospital or attending physic | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely, "led in by the funeral director, page 5 should be detached for use as the buris he find within 72 hours after heart, with the State Deut, of Health and Mental Hydiene prior to burial, compation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
|---|---|---|--|
| BO) | tificate b | physici ene prior | ther tra |
| P.0 | eath cer | attending Ital Hvoi | y, or 0 |
| RECORDS, | requires that the du | of Health and Men | shows any Injury |
| TAL | The law | ate has b | em 23 |
| <u> </u> | SICIAN: | the St | , or i |
| ON | IG PHYS | ter this | narked |
| SIO | TENDIN | DR: Aff | 8 18 |
| IVIC | OR AT | DIRECT | tem 2 |
| | SPITAL | VERAL I | THE THE |
| 0 | TO THE HOS | TO THE FUR. | IMPORTA |

al-transit permit. Pages 1, 2, 3 should

| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM | | | MENTAL HYGIENI REG. NO. | E . | |
|--------------------|---|--|--|------------------------------|----------------------|---|----------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | ALL OI | BEATT | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | VINCENT NATHA | NIEL LOMAX | | | | Sept. 8 | 1994 | 8:10p.m.M |
| | 4. SOCIAL SECURITY NUMBER | 6. SEX 6. AGE | | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BII | RTHPLACE (State or Foreign untry) |
| | 220-20-2973 | 1 XM 2 □ F 66 | YRS. | NTHS DAYS | HOURS MIN. | Aug. 9, 19 | 28 M | aryland |
| _ | 9a. FACILITY NAME (If not institution, give a | The state of the s | 9 | b. CITY, TOWN | OR LOCATION OF DE | HTA | 9c. COUNTY O | F DEATH |
| DIRECTOR | 3946 Dolfield | Avenue | | Baltin | nore | | | |
| Di l | 10a. STATE 10b. COUNT | Y | 10c. CITY, 1 | OWN OR LOCA | TION | | | 10d. INSIDE CITY |
| 5 | Maryland | | Bal | timore | 5 | | | 1 XYES 2 NO |
| M | 10e. STREET AND NUMBER | | | 10 | ZIP CODE | | 10g. CITIZEN C | OF WHAT COUNTRY? |
| FUNERAL | 3946 Dolfield | | | | 21215 | | U.S | |
| 5 | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER II FORCES? 1V YES IF YES, GIVE WAR OR D | N U.S. ARMED 2 NO | If yes, sp | ecity Cuban, Mexical | IC ORIGIN? (Specify Yes n, Puerto Rican, etc.) | 8 | ACE — American Indian, llack, White, atc. |
| BY | 3 Widowed 4 Divorced | Korean (| Conflict | 1 TYES | 2\ NO Specify | | S | Black |
| 9 | 15. DECEDENT'S EDU | | 16a. DECEDENT'S US | | | 16b. KIND OF BUS | INESS/INDUSTR | Y |
| COMPLETED | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 8 +) | (Give kind of world life. Do NOT use in | t done during mo etired.) | at or working | | | |
| MPI | | | Foreman | | | | | f Highways |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Maiden | Surname) | |
| BE | Melvin Lomax 19a. INFORMANT'S NAME (Type/Print) | | li de la constante de la const | | Flora | ? | | |
| 2 | Mary Louise L | om o w | I | | | Route Number, City or Town | | |
| | 204_METHOD OF DISPOSITION | | b. PLACE OF DISPOSITI | | | | MOTE. | MD 21215 |
| | X Buriel 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify) | novel from State | other place) | | | | | imore, Md. |
| | 21. SIGNATURE OF UNERAL SERVICE LI | | | | | CILITY | | eral HM PA |
| | > / Mount | 110-1-1 | low | harsi | latt W. | Jones, Jr | . Fund | eral HM PA |
| | 23. PART I. Enter the diseases, or | | | | | | | Approximate |
| | shock, or haert fellure. IMMEDIATE CAUSE (Final | List only one cause on a | V | | | | | Interval Between Onset and Death |
| | disease or condition resulting in death) | LUN | 6 C | ANC | ER | | | |
| | Transity in county | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | |
| N N | Sequentially list conditions, | b | | | | | | |
| Ě | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | A CONSEQUENCE OF): | | | | | |
| 임 | CAUSE (Disease or injury that initiated events | C. DUE TO (OR AS , | A CONSEQUENCE OF): | | | | | |
| CERTIFICATION | resulting in death) LAST | d | | | | | | |
| | PART II. Other aignificant condition | na contributing to death (| out not resulting in | the underlyin | a cause alven in | Part I. 24s. WAS AN | AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| PHYSICIAN: MEDICAL | | | at not to auditing in | | y cause given in | PERFOR | IMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | 1 [] YES 2 | □ NO | OF DEATH? |
| 3 | | | | | | | | 1 1 125 2 110 |
| Ä | 25. WAS CASE REFERRED TO MEDICAL | | | 26. P | LACE OF DEATH (Ch | eck only one) | | |
| Sic | EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Out | | THER: | ne 6 X Rasidence | 6 Other (Specify) | | |
| E | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 20b. TIME (| OF 28c. IN | JURY AT | 28d. DESCRIBE HOW I | NJURY OCCURE | D |
| BY | 1 Netural 6 Pending 2 Accident Investigation | - | | | YES 2 NO | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Spe | Y — At home, farm, str offy) | et, factory, offi | DB | 26f. LOCATION (Street in City or Town, State) | | rel Route Number, |
| Ę. | no. CENTIFIED | | | | | | | |
| COMPLETED | (Check only | BICIAN: To the best of my know ER: On the beals of examination | | | | | | (0) and manner or almost |
| 8 | | | on ancoor investigation, | in my opinion, | | | , | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIE | | () | | 29c. LICENSE NUI | D) | 29d, DATE SIG | NED (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WI | HO COMPLETED CAUSE OF DE | EATH (ITEM 27) (Type. P | rint) | | - / (| 7. | -1-17 |
| | A 14 - 5 | A~, MA 8 | 21 605 | 7A2) | 4 TZ | - 305 A | ALT IN | WITH AND AND |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGN | | 71 ~ | , | | 1000 | 3. 0 |
| | SEP 0 9 1994 | John Sinden-1 | Sandada. | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 flours after death. Page 6 may be retained by the hospital or attending physician. | 0 THF FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | be filed within 72 hours after death with the State Dept. of Health and Memail Hygiene prior to burial, cremation, or removal. | MPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|--|---|
| TO THE HOS | TO THE FUN | be filed with | IMPORTAN |

| 1. DECEDENT'S NAME (F) | y, Middle, Last) | 1- | | ZENTIF | ICATE | OF DEA | ^ | 2. DATE OF | REG. NO. | 7-9 | 4 | 3. TIME OF DEATH |
|--|---|--|--|--|--|--|--|---|--|--------------|-----------------------|---|
| HKI | PEI | <i><!--</i--></i> | | | ME/ | 15 | 4 | EPT | - 7 DAY | 190 | YEAR | 5:00 A |
| 4. SOCIAL SECURITY NUI | MBER | 5. SEX | 6. AGE (In. yrs. | lest birthday) YRS. | IF UNDER 1 Y | EAR IF UNDE | R 24 HRS. | 7. DATE OF | | igu | 8. BIRTHP Country) | LACE (State or Foreign |
| 9e. FACILITY NAME (If not | institution, give s | street and number) | / | | 9b. CITY, TO | OWN OR LOCAT | TION OF DEA | ATH | 1 | 9c. COUN | ITY OF DE | ATH |
| 9501 | Fair H | laven Av | renue | | Up | per | Mar1 | boro | | Pri | nce | Geo Co |
| RESIDENCE OF DE | 10b. COUNT | Y | | 10c, CIT | Y, TOWN OR I | LOCATION | | | | | | 10d. INSIDE CITY |
| Marvland | Prin | nce Geo | Co | | | r Mar | lhor | | | | | LIMITS? |
| 10s. STREET AND NUMBE | | ice ded | 00 | | орре | 10f. ZIP COL | | 0 | | 10g. CITIZ | | HAT COUNTRY? |
| 9501 Fa | ir Ha | ven Ave | nue | | | | 2 | 0772 | | | | |
| 11. MARITAL STATUS | 7 | 12. WAS DECEDEN | T EVER IN U.S. | ARMED | 13. WAS | B DECENDENT He, specify Cub | OF HISPANI | C ORIGIN? | Specify Yes | or No- | 14. RACE - | - American Indian, White, atc. |
| 1 Never Married 2 2 3 Widowed 4 Di- | _ | | MAR OR DATES | | | YES 2 NO | | | an, etc.) | | Specify | · |
| 15. DE | CEOENT'S EDU | CATION | 16e | DECEDENTS | USUAL OCCU | INATION | | 405 97 | MD OF BUILD | 11500 11101 | 1 Abrima | Black |
| (Specify of Elementary/Secondary | nly highest grade | completed) College (1-4 or 5 | | (Give kind of the Do NOT us | work done durk | ng most of work | ing | 100. KI | IND OF BUSI | NESS/INDI | USTRY | |
| Committee y occordes y | (0-12) | College (1-4 Of 5 | *) | | | | | | | | | |
| 17. FATHER'S NAME (First, | Middle, Last) | | | | | 18. MOT | THER'S NAM | E (First, Mick | die, Meiden S | umame) | | |
| | | | | | | | | | | | | |
| 190. INFORMANT'S NAME | (Type/Print) | | | 19b. MAILING | ADDRESS (S | treet and Numbe | er or Rural Ro | oute Number, | City or Town, | State, Zip | Code) | |
| | | | | | | | | | | | | |
| 200. METHOD OF DISPOSE 1 Description 2 Descr | tion 3 - Rem | oval from Stata | cometen | cromotons or o | OF DISPOSITIO | ON (Name of | | OATE | 20c. LOCA | ATION — C | Ity or Tow | n, State |
| 4 Donation 5 Donat | er (Specify) <u>i r</u> | 1 state | - remov | al | | | | 1 | | | | |
| 21. SUBSTITUTE OF PONER | , / | Ronal | d Wad | e,Diı | | | | | | | | Board |
| Juna | W | 1006 | el- | | | W.Bal | timo | re S | t, Ba | | | 1201 |
| IMMEDIATE CAUSE (F | | | ise on each ii | ne. | not enter the | mode of dy | /ing, such | aa cardia | c or reapire | etory arre | eat, | Approximata interval Between |
| disease or condition resulting in death) Sequentially list cond if any, leading to imm | Itions, ediate | a. arte DUE TO | JSE ON EACH II | Les SEQUENCE O | alie | e mode of dy | | | | | | interval Betwe |
| disease or condition resulting in death) Sequentially list cond | Itions, ediate YiNG lury | DUE TO | OR AS A CONS | Les SEQUENCE O | alie Pi: | | | | | | | interval Betwe |
| disease or condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter UNDERU CAUSE (Disease or in) that initiated events resulting in death) LA PART ii. Other aignific | itions, ediate ying lury ST | DUE TO | (OR AS A CONS (OR AS A CONS (OR AS A CONS | SEQUENCE OF | F): | las | | Part I. 24 | | UTOPSY IED? | 24b. V | Interval Betwee Onset and Dei |
| disease or condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter UNDERU CAUSE (Disease or in) that initiated events resulting in death) LA PART ii. Other aignific | itions, ediate ying lury ST | DUE TO DUE TO C. DUE TO | (OR AS A CONS (OR AS A CONS (OR AS A CONS | SEQUENCE OF | F): | las | | Part I. 24 | I. WAS AN AN PERFORM | UTOPSY IED? | 24b. V | VERE AUTOPSY FINDING TO DOMPLETION OF CAUSE OF DEATH? |
| Sequentially list condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter UNDERLY CAUSE (Disease or inj that initiated events resulting in death) LA PART ii. Other signific | itions, ediate ying lury ST | DUE TO DUE TO DUE TO d. DUE TO | (OR AS A CONS (OR AS A CONS (OR AS A CONS | SEQUENCE OF | F): | las | glven in P | Part I. 24 | I. WAS AN AN PERFORM | UTOPSY IED? | 24b. V | VERE AUTOPSY FINDING TO DOMPLETION OF CAUSE OF DEATH? |
| Sequentially list condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter UNDERLY CAUSE (Disease or in that initiated events resulting in death) LA PART II. Other aignific 25. WAS CASE REFERRED EXAMINER? 17 SYES 2 NO | itions, ediate ying lury ST | DUE TO DUE TO DUE TO C. DUE TO d. HOSPITAL: 1 Inpetient 2 | (OR AS A CONS (OR AS A CONS (OR AS A CONS (OR AS A CONS | REQUENCE OF TRANSPORT OF TRANSP | F): F): OTHER: 4 Nursing | CALL | given in P | rart I. 24 | Ae. WAS AN AN PERFORM | UTOPSY IED? | 24b. V | VERE AUTOPSY FINDING TO DOMPLETION OF CAUSE OF DEATH? |
| Sequentially list condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter UNDERLY CAUSE (Disease or in that initiated events resulting in death) LA PART II. Other aignific 25. WAS CASE REFERRED EXAMINER? 17 LYES 2 \(\) NO 27. MANNER OF DEATH | itions, ediate ying structure is and condition classic condition to MEDICAL | DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO | (OR AS A CONS (OR AS A CONS (OR AS A CONS death but not LLL ER/Outpatient INJURY | EQUENCE OF TEMPERATURE OF THE PROPERTY OF THE | OTHER: 4 Nursing E OF 284 | rlying cause Ra. PLACE DF (Home 5 R C. INJURY AT WORK? | given in P | tart i. 24 1 1 Chart only one) | Ae. WAS AN AN PERFORM | UTOPSY NO NO | 24b. V | VERE AUTOPSY FINDING TO DOMPLETION OF CAUSE OF DEATH? |
| Sequentially list condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter UNDERLU CAUSE (Disease or in that initiated events resulting in death) LA PART II. Other signific CAUSE (Disease or in that initiated events resulting in death) LA PART II. Other signific CAUSE (Disease or in that initiated events resulting in death) LA 25. WAS CASE REFERRED EXAMINER? 1 | itions, ediate ying lury ST | DUE TO DUE TO DUE TO DUE TO DUE TO HOSPITAL: 1 Inperient 2 December 1 December 2 D | (OR AS A CONS (O | REQUENCE OF TRANSPORTED TO THE PROPERTY OF THE | OTHER: 4 Nursing E OF URY M 1 | PLACE DF IN HOME S T WORK? | given in P | Part I. 24 1 Other (S 28d, DESCR | Ne. WAS AN AN PERFORM VES 2 | UTOPSY IED? | 24b. V | VERE AUTOPSY FINDING MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? I YES 2 NO |
| Sequentially list condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter UNDERLY CAUSE (Disease or in that initiated events resulting in death) LA PART II. Other alignific 25. WAS CASE REFERRED EXAMINER? 1 SAYES 2 NO 27. MANNER OF DEATH 1 Natural 5 Accident | Itions, ediate VING Jury ST Cant condition To MEDICAL | DUE TO DUE TO DUE TO DUE TO C. DUE TO d. HOSPITAL: 1 Inpetient 2 26e. PLACE OF | (OR AS A CONS (OR AS A CONS (OR AS A CONS death but not LLL ER/Outpatient INJURY | REQUENCE OF TRANSPORTED TO THE PROPERTY OF THE | OTHER: 4 Nursing E OF URY M 1 | PLACE DF IN HOME S T WORK? | given in P | rart I. 24 1 1 Other (S 28d, DESCR | Na. WAS AN AN PERFORM YES 2 | UTOPSY IED? | 24b. V | VERE AUTOPSY FINDING MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? I YES 2 NO |
| Sequentially list condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter UNDERLY CAUSE (Disease or in that initiated events resulting in death) LA PART II. Other aignific 25. WAS CASE REFERRED EXAMINER? 1 SAMINER OF DEATH 1 Natural 5 Accident 3 Suicide 6 Homicide | itions, ediate VING lury ST Cant condition TO MEDICAL Could not be determined | DUE TO DUE TO DUE TO DUE TO C. DUE TO d. HOSPITAL: 1 □ Inpetient 2 □ 26e. DATE OF (Month, D) 26e. PLACE OF building, | (OR AS A CONS (OR AS A CONS (OR AS A CONS death but not ER/Outpatient INJURY ey, 'bear') FINJURY — At I stc. (Specify) | EQUENCE OF THE PROPERTY OF THE | F): F): OTHER: 4 Nursing E OF 28(URY M 1) streel, factory, | rlying cause Ra. PLACE DF II Home 5 R C. INJURY AT WORK? YES 2 [office | given in P | Part I. 24 1 Other (S 28d. DESCR | Specify) ON (Street and John, State) | JURY OCCI | 24b. V | VERE AUTOPSY FINDING MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? I YES 2 NO |
| Sequentially list condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter UNDERLY CAUSE (Disease or in that initiated events resulting in death) LA PART ii. Other alignific that initiated events resulting in death) LA PART ii. Other alignific that initiated events resulting in death) LA 25. WAS CASE REFERRED EXAMINER? 17 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Accident 3 Suicide 6 4 Homicide 29e. CERTIFIER (Check only) | itions, ediate VING lury ST Cant condition Calculation TO MEDICAL Could not be determined COURT OF THE COURT | DUE TO b. DUE TO c. DUE TO d | (OR AS A CONS (OR AS A CONS (OR AS A CONS death but not ER/Outpatient ENJURY At (Specify) my knowledge, | BEOUENCE OF TEMPLE OF THE PROPERTY OF THE PROP | F): F): OTHER: 4 Nursing E OF 28, URY M 1 | riying cause Ra. PLACE DF II Home 5 R R C. INJURY AT WORK? YES 2 [office | given in P DEATH (Chec | rart I. 24 1 1 Other (S 28d, DESCR | Specify) NBE HOW IN. ON (Street and flown, State) | JURY OCCI | 24b. v | VERE AUTOPSY FINDING WAIL ABLE PRIOR TO DOMPLETION OF CAUSE OF DEATH? I YES 2 NO |
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| Sequentially list condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter UNDERLY CAUSE (Disease or in that initiated events resulting in death) LA PART II. Other aignific 25. WAS CASE REFERRED EXAMINER? 1 Syles 2 NO 27. MANNER OF DEATH 1 Natural 5 Natural 5 Accident 3 Suicide 6 Homicide 29e. CERTIFIER (Check only one) ME | itions, ediate ying lury ST Cant condition Cant condition To MEDICAL Pending Investigation Could not be determined ATTIFYING PHYSIC | DUE TO b. DUE TO c. DUE TO d | (OR AS A CONS (OR AS A CONS (OR AS A CONS death but not ER/Outpatient ENJURY At (Specify) my knowledge, | BEOUENCE OF TEMPLE OF THE PROPERTY OF THE PROP | F): F): OTHER: 4 Nursing E OF 28, URY M 1 | rlying cause 28. PLACE DF (Home 5 R C. INJURY AT WORK? YES 2 [office date and place on, death occur | given in P DEATH (Checked and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second | Part I. 24 1 Other (S 28d. DESCR City or 1 o the cause(me, dete and | Specify) IN Street arrifown, State) (e) and mennd d place, end | JURY OCCI | 24b. V | VERE AUTOPSY FINDING WAIL ABLE PRIOR TO DOMPLETION OF CAUSE OF DEATH? I YES 2 NO |
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| Sequentially list condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter UNDERLY CAUSE (Disease or in that initiated events resulting in death) LA PART II. Other aignific 25. WAS CASE REFERRED EXAMINER? 1 Syles 2 NO 27. MANNER OF DEATH 1 Natural 5 Natural 5 Accident 3 Suicide 6 Homicide 29e. CERTIFIER (Check only one) ME | itions, ediate VING Jury ST Cant condition Cant Condition TO MEDICAL Pending Investigation Could not be determined RTIFYING PHYSIC DICAL EXAMINE! | B. DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO C. DUE TO C. DUE TO DUE TO C. DUE TO C. DUE TO DUE TO C. DUE TO C. DUE TO DUE TO C. DUE TO C. DUE TO DUE TO DUE TO C. DUE TO DUE TO DUE TO C. DUE TO C. DUE TO DU | (OR AS A CONS (OR AS A CONS (OR AS A CONS death but not ER/Outpatient INJURY ley, 'bear') FINJURY — At lete. (Specify) my knowledge, xamination end/of | DOA 28b. TIM INJ | F): F): OTHER: 4 Nursing E OF UNY M 1 streel, fectory, n, in my opini | rlying cause 28. PLACE DF (Home 5 R C. INJURY AT WORK? YES 2 [office date and place on, death occur | given in P DEATH (Checked and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second and the second | Part I. 24 1 Other (S 28d. DESCR City or 1 o the cause(me, dete and | Specify) IN Street arrifown, State) (e) and mennd d place, end | JURY OCCI | 24b. V | Interval Betwee Onset and De. Onset and De. Onset and De. Onset and De. Onset and De. Onset and To. |

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TO THE HOSPITAL OF ATTENDATION TO THE law requires that the death certificate be executed with chospital or stending by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 h.

31. DATE FILED (MONTH, Day, Year)

32. REGISTRAR'S SIGNATURE

| | | | | | | | | 4 26425 | | |
|--|--|--|--|---|---|---|--|--|--|--|
| | 1 - STATE REGISTRAR | STATE OF MARYL | | TMENT OF H | | MENTAL HYGIEN | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | OLITTI | ICATE OF | DEATH | 2. DATE OF DEATH | 7. | 3. TIME OF DEATH | | |
| | ROBERT LEE | MEEKS | | | | | 06 94 | 8:35P | | |
| | 4. SOCIAL SECURITY NUMBER | | (In vrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | BIRTHPLACE (State or Foreign | | |
| | | 1 X M 2 D E | , ype | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) | | Country) | | |
| | 220-52-3676 | | 14 THS. | | | 01 29 | 50 M | laryland | | |
| | 9e. FACILITY NAME (If not institution, give | street end number) | | 9b. CITY, TOWN O | R LOCATION OF D | EATH | 9c. COUNTY | OF DEATH | | |
| CTOR | 2604 GUILFORD | AVENUE | | BALTI | MORE | CITY | _ | | | |
| [2] | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT | TV | 100 0173 | Y, TOWN OR LOCAT | ION | | | | | |
| OBI | | | 100. 011 | | | + | | 10d. INSIDE CITY LIMITS? | | |
| | Maryland 100 STREET AND NUMBER | | | | ore Ci | Ly | | 1 🔼 YES 2 🗌 NO | | |
| FUNERAL | | | | 101. | ZIP CODE | | | OF WHAT COUNTRY? | | |
| y H | 2604 Guilford | | | | 2121 | | US | 6A | | |
| 15 | 11. MARITAL STATUS 1 Never Married 2 Merried | 12. WAS DECEDENT EVER I | N U.S. ARMED | | | NIC ORIGIN? (Specify Year, Puerto Rican, etc.) | s or No — 14. | RACE - American Indian, Black, White, etc. | | |
| ₽ | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR D | ATES | | 2 XNO Specif | | | Specify: | | |
| ED | 45 050505050 50 | <u> </u> | | 1 | | | | Black | | |
| ETE | 15. DECEDENT'S EDI (Specify only highest grad | le completed) | | VSUAL OCCUPATION Vork done during mos | | 16b. KIND OF BU | ISINESS/INDUST | IRY | | |
| 1 2 | Elementary/Secondary (0-12) | College (1-4 or 5 +) | Driv | * | | Morr f 1 | N 2011 | Company | | |
| OMPL COMPL | | | חדדי | ver | | | | Ollipatry | | |
| 5 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Maider | | | | |
| ed a | Ervin Meeks | | | | | le Alsto | | | | |
| 10 0 | 19e. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or Tov | | | | |
| be notified at once. TO BE COM | Lucille Meeks | | 2604 | Guilfo | rd Ave | . Balto | , MD 2 | 21218 | | |
| | 206. METHOD OF DISPOSITION 1 A Burtal 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) 4 Donation 5 D Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery) 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State 20c. Balto, CO. MD | | | | | | | | | |
| Ē | 4 Donation 5 D Other (Specify) | | . Zion | | | | Balto, | CO. MD | | |
| e le | 21. BIGNATURE OF FUNERAL BERVICE L | CENSEE | 1 | 22. NAME AN | D ADDRESS OF FA | ral Home | | | | |
| medical examiner must | I Tament d | K. Eme | 4- | | | th Avenue | D 0 1 | to, MD 2120 | | |
| ES - | 23. PART I. Enter the diseases, or | complications that cause | d/ha daath. Do n | | | | Iretory errest | Approximate | | |
| Be | shock, or heart failure. | . List only one cause on a | ach line. | | -a or aying, oad | aa aararaa ar raap | matory arrest | Intarval Between | | |
| the state of | IMMEDIATE CAUSE (Final disease or condition | A COLLEGE | TAMILINIT | DEELCI | TENOV C | VNDDOME | | Onset and Death | | |
| f. | resulting in death) | a. ACQUIRED | CONSEQUENCE OF | | LENCI S | INDROME | | | | |
| or other traumatic event, ERTIFICATION | | | · condeduction of | ,. | | | | j | | |
| y, or other traumatic CERTIFICATION | Sequentially list conditions, Due to (or as a consequence of): | | | | | | | | | |
| AT | if any, laading to immediata cause. Enter UNDERLYING | | | , | | | | j | | |
| F | CAUSE (Disease or Injury that Initiated events | C. DUE TO (OR AS / | CONSEQUENCE OF | n: | | | | | | |
| 5 E | reaulting in daeth) LAST | w | | | | | | | | |
| S E | | d | | | | | | | | |
| 흺 그 | PART II. Other algnificant condition | na contributing to death b | out not resulting i | n tha undariying | causa given in | | | 24b. WERE AUTOPSY FINDINGS | | |
| DICA | l | | | | | PERFO | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | |
| MA CHI | | | | | | INQU | | OF DEATH? | | |
| 23 shows any AN: MEDIC | DID TOBACCO USE CONT | PIRLITE TO CALISE O | E DEATH VE | s D NO D | UNCERTAI | | IVI | 1 YES 2 NO | | |
| | 25. WAS CASE REFERRED TO MEDICAL | TRIBUTE TO CAUSE C | 26. PLACE OF DEAT | | OIACEKIAII | | | | | |
| WSICI, | EXAMINER? XXYES 2 \(\square\) NO | HOSPITAL: 1 Inpatient 2 ER/Out | | OTHER: | 1 - 20000 · | III TEE STEADE | | | | |
| =1 2 | | 1 - Inpatrient 2 - En/Out | | | | 6 Other (Specify) | IN HIEV OCCUR | ED | | |
| | | 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 18JURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED NJURY | | | | | | | | |
| 필표 | | 28e. DATE OF INJURY (Month, Day, Year) | | | | 1 | | | | |
| BY PH | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJ | M 1 🗆 Y | ES 2 NO | 201 I OCATION (C) | | | | |
| be my led. | 27. MANNER OF DEATH 1 Netural 5 Pending | (Month, Day, Year) | — At home, farm, s | M 1 🗆 Y | ES 2 NO | 281. LOCATION (Street City or Town, State | | Rural Route Number, | | |
| ETED BY PH | 27. MANNER OF DEATH 1 Netural S Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined | (Month, Day, Year) 28e. PLACE OF INJURY | — At home, farm, s | M 1 🗆 Y | ES 2 NO | | | Rural Route Number, | | |
| ETED BY PH | 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only 1 CERTIFYING PHYS | 28e. PLACE OF INJURY building, stc. (Special Annual Control of the best of my known and the best | — At home, farm, s | M 1 Y | end place, and due | City or Town, State | nner aa stated. | | | |
| ETED BY PH | 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only 1 CERTIFYING PHYS | (Month, Dey, Year) 28e. PLACE OF INJURY building, etc. (Spe- | — At home, farm, s | M 1 Y | end place, and due | City or Town, State | nner aa stated. | | | |
| ETED BY PH | 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only 1 CERTIFYING PHYS | (Month, Dey, Year) 28e. PLACE OF INJURY building, stc. (Spe- SICIAN: To the best of my know ER: On the bests of exeminates | — At home, farm, s | M 1 Y | end place, and due | City or Town, State to the cause(e) end me time, date end place, en | nner as stated. Ind due to the ce | suse(e) end manner ee steted. GNED (Month. Dev. Yeer) | | |
| BE COMPLETED BY PH | 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident 5 Pending Investigation 3 Suicide 8 Could not be determined 29s. CERTIFIER (Check only one) 2 NEDICAL EXAMIN | (Month, Dey, Year) 28e. PLACE OF INJURY building, stc. (Spe- SICIAN: To the best of my know ER: On the bests of exeminates | — At home, farm, s | M 1 Y | end place, and due | City or Town, State to the cause(e) end me time, date end place, en | nner as stated. Ind due to the ce | suse(e) end manner ee steted. | | |
| E COMPLETED BY PH | 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident 5 Pending Investigation 3 Suicide 8 Could not be determined 29s. CERTIFIER (Check only one) 2 NEDICAL EXAMIN | 28e. PLACE OF INJURY building, stc. (Special Control of the best of my known of the best of the best of the best of the best of exeminating the best of the best of exeminating the best of the best of exeminating the best of the best of exeminating the best of the best o | Indiana At home, farm, a ledge, death occurre n and/or investigation with (ITEM 27) (Type, | M 1 V Atreet, factory, office and at the time, date n, in my opinion, de | end place, and due seth occured at the 29c. LICENSE NUI | City or Town, State to the cause(e) end me time, date end place, en | nner as stated. and due to the call to th | GNED (Month, Day, Year) EPT • 07/94 | | |

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1 - FOR STATE REGISTRAR

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| VISION OF VITAL RECORDS, P.O. BOX 68760 | andification |
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| | 1 - STATE REGISTRAR | STATE OF MARYLA | ND / DEPAR | TMENT OF | HEALTH AND I | MENTAL HYGIE | | | 0 120 |
|-------------|---|---|--------------------------|----------------------------|-----------------------------|--|---------------|---|------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | MARINE | | | - | 2. DATE OF DEATH MONTH | DAY | YEAR 3. | TIME OF DEATH |
| | CHARLES E. | | | | | | | 34 | 11:15 A |
| | 217-28-3954 | 1X M 2 □ F 5 | 2 YRS. | F UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | JUL 6, 1 | 932 | Country) MARY | CE (State or Foreign |
| стов | | et and number) | | | OR LOCATION OF DE | CITY | 9c. COUNT | n/a | |
| DIRECT | 100. STATE 100. COUNTY MARYLAND 100. COUNTY | / a | 10c. CIT | y, TOWN OR LOCA BAL | TIMORE | | | | 1. INSIDE CITY LIMITS? |
| FUNERAL | 100. STREET AND NUMBER 6608 PA | RR AVENUE | | 10 | of. ZIP CODE 21215 | | UNIT | | STATES |
| B≺ | 11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN L FORCES? 1 V YES IF YES, GIVE WAR OR DATE | I.S. ARMED 2 NO ES | II yes, s | | NC ORIGIN? (Specify Y ri, Puerlo Ricen, etc.) | es or No— | I4. RACE — Black, W Specify: | American Indian, hita, atc. |
| 9 | 15. DECEDENT'S EDUCA (Specify only highest grade co | | 6a. DECEDENT'S | USUAL OCCUPAT | ION | 16b. KIND OF B | USINESS/INDU | STRY | |
| COMPLET | | College (1-4 or 5+) | MACHI | se retired.) | ERATOR | n/ | a | | |
| l iii | 17. FATHER'S NAME (First, Middle, Last) CHARLES | W. MARINE | | | 18. MOTHER'S NA | ME (First, Middle, Maide | E S | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) MARY MA | RINE | 19b. MAILING 660 | ADDRESS (Street | and Number or Rural I | UE, BALT | "I MORE | ode) M[| 21215 |
| | 20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remove 4 Donation 5 Other (Specify) | | | OF DISPOSITION (A | PARK | DATE 20c. L | RANDA | | State OWN, MD |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | 3/ Allan | d | | C. MARC | ситу Н FH. –11 | 01 6 | E. NO | ORTH AV |
| | 23. PART I. Enter the diseases, or conshock, or heart failure. Lie | mplications that caused t | he deeth. Do r | not enter the m | ode of dying, suc | h ss cerdiec or res | piratory erre | st, | Approximate |
| | IMMEDIATE CAUSE (Finel | | | | | | | | Interval Between Onset and Deat |
| | resulting in dasth) e. | Septice DUE TO (OR AS A C | | | 10: | SEVIET DE | 4 | | (925) |
| TION | If any, leading to immediate DUE to (OR AS A CONSEQUENCE OF) | | | | | | | | IIno |
| RTIFICATION | csuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A C | Encept ONSEQUENCE OF | nelopa | thy | | | | |
| 뜅 | PART II. Other significent conditions | contributing to deeth but | not resulting | In the underlyis | ng cause given in | Part I 24e WAS A | N AUTOPSY | 24h WE | RE AUTOPSY FINDINGS |
| 4.5 | | HF | | | | | PRMED? | CO DF | MPLETION OF CAUSE DEATH? |
| | DID TOBACCO USE CO | ONTRIBUTE TO C | AUSE OF | DEATH ' | YES NO | | | 1 (| YES 2 1 HO |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | PLACE OF DEATH (Ch | eck only one) | | | |
|] | 1 YES 2 NO | 28a. DATE OF INJURY | ent 3 DOA 28b. TIM | | me 5 Residence | 6 Other (Specify) | INJURY OCCI | RED | |
| ВУ Р | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJ | URY W | ORK? YES 2 NO | 200. 02401102 11011 | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — building, etc. (Specify | At home, farm, | street, lactory, offi | ca | 281. LOCATION (Stree City or Yown, Stat | | r Rural Route | Number, |
| COMPLÉTED | | AN: To the best of my knowled On the beals of examination a | | | | | | | d manner as stated. |
| 98 | 296. SIGNATURE AND TITLE OF CERTIFIER | 0.4 | | | 29c. LICENSE NUM | | 29d. DATE | SIGNED (MO | onth, Day, Year) |
| 일 | 30. NAME AND ADDRESS OF PERSON WHO | | | Print) | L | | | 1-1. | 1 |

WILLIAMS STREET OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

The Following of the Print Center of the Print)

The Following of the Print Center of

3001 S. Hanoverst. Baltina

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within and received within and received and the retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be fined with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTINE: If them is marked, or litem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| 1 | nedis Inan | | | | JE DEALH | • | REG. NO. | | | | | | | |
|------------------------------------|--|--|--|--|----------------------|--|---|---|-------------------|--|--|--|--|--|
| 1 1 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. D/ | ATE OF DEATH | | 100 | 3. TIME OF DEATH | | | | |
| | Anne E. I | McDonough | | | | | /8/94 | ¥ | YEAR | 2:15 p. M | | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGI | E (In yrs. last birthday | IF UNDER 1 YE | AR IF UNDER 24 H | HRS. 7. DA | ATE OF BIRTH | | a. BIRTI | IPLACE (State or Foreign | | | | |
| 1 | 220-38-7919 | 1 🗌 M 2 😡 F | 91 YRS. | MONTHS DA | YS HOURS M | um. (M | /28/1903 | ء ا | Counti | IPLACE (State or Foreign ry) Md | | | | |
| | 9e. FACILITY NAME (If not Institution, give s | | | 96 CITY TO | WN OR LOCATION | | 720/1903 | | NTY OF D | | | | | |
| Œ | Chapel Hill Conv. | * | | | llstown | OF DEATH | | 1000 | | | | | | |
| 16 | RESIDENCE OF DECEDENT | Manua | IISLOWII | | | Baltimore | | ore | | | | | | |
| | 10a. STATE 10b. COUNT | Υ | 10c. C | TY, TOWN OR L | OCATION | | | | | 10d. INSIDE CITY | | | | |
| DIRECTOR | Md Howa | ard | E | llicot | City | | | | | LIMITS? | | | | |
| | 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | | 40 - OIT | TEN OF I | WHAT COUNTRY? | | | | |
| FUNERAL | 3004 North Ridg | ro Road | | | 21043 | | | iog. Citi | USA | WHAT COONTRY? | | | | |
| 💆 | 11. MARITAL STATUS | | | | | | | Ц., | | | | | | |
| | 1 Never Married 2 Merried | 12. WAS DECEDENT EVER FORCES? 1 YES | S 2 NO | If ye | DECENDENT OF H | dexicen, Puer | IGIN? (Specify Year rto Rican, atc.) | or No- | 14. RACI Black | E — Americen Indien, k, White, etc. | | | | |
| l Mg | 3 XWidowed 4 Divorced | IF YES, GIVE WAR OR | OATES | 1 🗆 | YES 2 NO S | Specify: | | | Spec | tty: | | | | |
| | 15. DECEDENT'S EDU | ICATION | 18e. DECEDENT | | | | | l | | white | | | | |
| COMPLETED | (Specify only highest grade | completed) | (Give kind o | work done during | g most of working | | 16b. KIND OF BUS | INESS/INC | DUSTRY | | | | | |
| 1 2 1 | Elementary/Secondery (0-12) | College (1-4 or 5+) | 470 | | - | | Corre | | | | | | | |
| N N | 17. FATHER'S NAME (First, Middle, Last) | | 26 | cretar | | | Gover | | L | | | | | |
| | Charles Kruhm | | | | | , | st, Middle, Meiden : | Surname) | | | | | | |
| BE | | | | | | | Miegel | | | | | | | |
| 2 | 19e. INFORMANT'S NAME (Type/Print) | | | | reet end Number or I | | | | Code) | | | | | |
| - | Casimir Karzak | | 935 | Regina | Drive, | Balto | , Md. 21 | 1227 | | | | | | |
| | 20e. METHOD OF DISPOSITION 1 □ Burlel 2 😾 Cremation 3 □ Rem | | ob. PLACE AND DATI | | N (Name of | 1 | | CATION — | City or To | own, State | | | | |
| | 4 Donation 5 Other (Specify) | G | reenmoun | t Crema | tory | 9 | /9 Balt | imor | e, M | 1d. | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE DE | CENSEE | | | E AND AOORESS | | | | | | | | | |
| | | - Dabl. C | N 11 | | erling A | | | | | | | | | |
| \vdash | 23. PART I. Enter the diseases, or | complications that cause | IN OUD II | 736 | Edmond | son A | ve. Balt | 0. N | [d, 2] | | | | | |
| | ahock, or heart fallure. | List only one cause on | eech line. | not onter the | mode of dying, | , auch as c | seroiac or reepii | atory en | eet, | Approximate interval Between | | | | |
| | iMMEDIATE CAUSE (Final disease or condition | Athero | . / | 1. | 1 | 11 | / / | 1 | | Onset and Death | | | | |
| | resulting in death) | | | | 600000 | , 0 | A) (W) ~ | U | , , , , , | | | | | |
| | | OUE TO (OR AS | A CONSEQUENCE | OF): | | | | | | | | | | |
| 1 - 1 | Sequentially list conditions, | b | | | | | | | | | | | | |
| 151 | | DUE TO (OR AS | A CONSEQUENCE | OF): | | | | | | | | | | |
| TION | if any, leading to immediate | | | | | | | | | | | | | |
| ICATION | | С | | CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| TIFICATION | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | cOUE TO (OR AS | A CONSEQUENCE | OF): | | | | resulting in deeth) LAST | | | | | | |
| ERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | C. DUE TO (OR AS | A CONSEQUENCE | OF): | | | | | | | | | | |
| L CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST | d | | | lving ceuse give | en in Pert I | 24a WAS AN | AIITOPSV | 246 | WEDE AUTOREV EINOMOS | | | | |
| | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST | d | but not requiting | in the under | lying ceuse give | en in Pert I. | , 24s. WAS AN / PERFOR | | 24b | WERE AUTOPSY FINGINGS | | | | |
| | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other significant condition CR-46 | d | but not requiting | in the under | lying ceuse give | en in Pert I. | . 24a. WAS AN PERFORI | MED? | 24b | | | | | |
| MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other significant condition CR-45 | d | but not requiting | in the under | | | PERFOR | MED? | 24b | AMAILABLE PRIOR TO COMPLETION OF CAUSE | | | | |
| MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST PART II. Other significant condition Cartination Demantic Did mantical | d | but not requiting | in the under | | NO [| PERFOR | MED? | 24b | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? | | | | |
| MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST PART II. Other significant condition CR-4 J | d | but not requiting | DEATH | | ио □ | PERFORI | MED? | 24b | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? | | | | |
| MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other significant condition CR-16-10 DEM CO FINE DID TOBACCO USE (25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 PAO | d | but not resulting Accord | DEATH | YES 🔲 | NO [| PERFORI 1 YES 2 y one) | MED? | 24b | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? | | | | |
| MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other significant condition Resulting in deeth LAST DID TOBACCO USE (Cause) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 PAO 27. MANNER OF DEATH | CONTRIBUTE TO HOSPITAL: 1 lopatient 2 ER/Ou 286. DATE OF INJURY | but not resulting CAUSE OI | DEATH OTHER: WE OF 128 | YES | NO [] TH (Check only | PERFORI 1 YES 2 y one) | MED? | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? | | | | |
| PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other significant condition PART II. Other signi | d | but not resulting CAUSE OI | DEATH OTHER: 4 Winning ME OF 286 | YES | NO [] TH (Check only) ence 6 0 0 28d. | PERFORI 1 YES 2 y one) Wher (Specily) | MED? | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? | | | | |
| MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other significant condition PART II. Other signi | d | CAUSE OF | DEATH OTHER: 4 Wursing ME OF 286 JURY M 1 | YES | NO LITH (Check only ence 6 0 0 28d. 10 | PERFORI 1 YES 2 y one) Wher (Specily) DESCRIBE HOW IN | MED? | CURED | AMALABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO | | | | |
| BY PHYSICIAN: MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other significant condition PART II. Other signi | CONTRIBUTE TO HOSPITAL: 1 Inpetient 2 ER/Out (Month, Day, Year) | CAUSE OF | DEATH OTHER: 4 Wursing ME OF 286 JURY M 1 | YES | NO LITH (Check only ence 6 0 0 28d. 10 | PERFORI 1 YES 2 y one) Other (Specily) DESCRIBE HOW IN | MED? | CURED | AMALABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO | | | | |
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| BY PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other significant condition PART II. Other signi | CONTRIBUTE TO HOSPITAL: 1 Inpatient 2 ER/Ou 28e. DATE OF INJUR (Month, Dey, Year) 28e. PLACE OF INJUR building, stc. (Sp. | CAUSE OI tipstlent 3 DOA 28b. Ti RY — At home, ferm. | DEATH OTHER: 4 ® Nursing ME OF 1 streat, factory, | YES | NO IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII | PERFORI 1 YES 2 Wher (Specily) DESCRIBE HOW IN OCATION (Street e. City or Town, State) | MED? NO IJURY Oct and Number | or Rural F | AMALABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO | | | | |
| O MENETED BY PHYSICIAN: MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other significant condition Resulting in deeth) LAST PART II. Other significant condition Resulting in deeth) LAST DID TOBACCO USE (Condition of the conditi | CONTRIBUTE TO HOSPITAL: 1 Inpatient 2 ER/Ou 28e. DATE OF INJUR (Month, Dey, Year) 28e. PLACE OF INJUR building, stc. (Sp. | CAUSE OI tipstlent 3 DOA 28b. Ti RY — At home, ferm. | DEATH OTHER: 4 ® Nursing ME OF 1 streat, factory, | YES | NO DH (Check only ence 6 0 0 28d. 10 28f. L | PERFORI 1 YES 2 Wher (Specily) DESCRIBE HOW IN OCATION (Street e. City or Town, State) | MED? HO IJURY Oct Ind Number There as stated due to the | or Rural F | AMALABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO | | | | |
| BE COMPLETED BY PHYSICIAN: MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST PART II. Other significant condition PART II. Other signi | CONTRIBUTE TO HOSPITAL: 1 Inpatient 2 ER/Ou 28e. PLACE OF INJUR 28e. PLACE OF INJUR building, stc. (Sp. | CAUSE OI Ty — At home, term, early) The end or investiget When the control of | DEATH OTHER: 4 Mureing ME OF 18 streat, factory, red at the time, ion, in my opinis | YES | NO DH (Check only ence 6 0 0 28d. 10 28f. L | PERFORI 1 YES 2 Wher (Specily) DESCRIBE HOW IN OCATION (Street e. City or Town, State) | MED? HO IJURY Oct Ind Number There as stated due to the | or Rural F | AMALABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO Route Number, | | | | |
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| BE COMPLETED BY PHYSICIAN: MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST PART II. Other significant condition PART II. Other signi | CONTRIBUTE TO HOSPITAL: 1 Inpatient 2 ER/Ou 28e. PLACE OF INJUR 28e. PLACE OF INJUR building, stc. (Sp. | CAUSE OI Ty — At home, term, early) The end or investiget When the control of | DEATH OTHER: 4 Mureing ME OF 18 streat, factory, red at the time, ion, in my opinis | YES | NO CH (Check only ence 6 O O O O O O O O O O O O O O O O O O | PERFORI 1 YES 2 Wher (Specily) DESCRIBE HOW IN OCATION (Street e. City or Town, State) | JURY Oct not Number as stated due to the | or Rural F | AMALABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO Route Number, | | | | |
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| | 1 | Item#20c | Per | F.H. | Film# | G-715 | 09/09 | 1/94 R | M |
|---|---|---------------------------|-----|------|-------|------------|----------|---------|----|
| | | FOR STATE REGISTRAR | | | | AND / DEPA | | | |
| _ | | REGISTRAR | | | | CERTIF | FICATE (| OF DEAT | ГН |

| | | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPAR CERTIF | RIMENT OF I | HEALTH AND I DEATH | MENTAL HYGIEN REG. NO | | |
|---|---------------------------------|--|--|--|--|--|---|------------------|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | Eugene Jo | | | | 2. DATE OF DEATH | AY Y | 3. TIME OF DEATH |
| | | 4. SOCIAL SECURITY NUMBER | 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDE | | | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | 994 M BIRTHPLACE (State or Foreign |
| 70 | | 216-28-9626 | XX M 2 □ F 6 | 2 YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) 07/22/19 | | Country) Maryland |
| 3 should | - | 9e. FACILITY NAME (If not institution, give stre | eet and number) | | 96. CITY, TOWN | OR LOCATION OF DE | | 9c. COUNTY | |
| 6 | CTOR | 6909 Broening Road Dundalk Baltimore | | | | | | | |
| Jes 1, | ш | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | 10c, CIT | Y, TOWN OR LOCA | TION | | | 10d. INSIDE CITY |
| permit. Pages | L DIR | Maryland 100. STREET AND NUMBER | Baltimore | | | Du | ndalk | , | 1 TYES 2 THO |
| | RA | 6909 Broening Ro | ad | | 10 | 1. ZIP CODE | 1000 | | N OF WHAT COUNTRY? |
| 020 physician. burial-transit | FUNER | | 12. WAS DECEDENT EVER IN | N U.S. ARMED | 13. WAS DEC | | 1222 HC ORIGIN? (Specify Yes | | ited States RACE — American Indian, |
| 5-0020 inding physic as the burial | | 1 Never Merried 2 Married | FORCES? 1 X YES | 2 NO | If yes, sp | | n, Puerto Ricen, etc.) | JOI NO. | Black, White, etc. Specify: |
| 215-00 attending | D BY | 3 Widowed 4 Divorced | Korean Con | | | ~ | | | White |
| Se at S | ш | 15. DECEDENT'S EDUCA (Specify only highest grade of | ATION completed) | (Give kind of v | Work done during mo | ON ost of working | 16b. KIND OF BU | SINESS/INDUS | TRY |
| D 21 pital or ed for u | 1 2 | Elementery/Secondary (0-12) 12th Grade | College (1-4 or 5+) | Mana | | | 1.000 | . 04 | |
| The hospital detached to | COMPLET | 17. FATHER'S NAME (First, Middle, Last) | marta | ger | 18. MOTHER'S NA | ME (First, Middle, Maiden | or Stor | ie | |
| Z & & Z | նի ա հ | Joseph W. Myers | | | | End of the second live | Kresina | Surramey | |
| retained by the hospit 5 should be detached | 0 0 | 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street a | | Route Number, City or Tow | n, State, Zip Co | ode) |
| | | Mrs. Helen B. My | ers | 6909 | Broenin | g Road | Dundalk, N | larular | nd 21222 |
| ORE, e 6 may be vertor, page | | 20a, METHOD OF DISPOSITION 1 🗗 Buriel 2 🗆 Cremation 3 🗆 Remov | val from State com | PLACE AND DATE | OF DISPOSITION (Na | ame of | | | |
| Page 6 I direct | | 4 Donation 5 Other (Specify) | Ch | iest Law | n Mem. G | dns 9/8/ | 94 E | altimo | TSVILLE TSVILLE Le Maryland |
| BALTIMOR in death. Page 6 ma the funeral director, p. sel. | | 21. SIGNATURE OF FUNERAL SERVICE LICE | NSEE / | | Duda | ND ADDRESS OF FAI | CILITY | | ındalk, Inc. |
| BAI on the fact | | Johnsey L. | BUG | 571 | _ 7922 | Wise Au | e. Dundal | k. Man | uland 21222 |
| n by n | | 23. PART I. Enfet the diseases, or co ahook, or heart fallure. Li | implications that caused | tha death. Do n | not antar the mo | da of dylng, suci | h as cardiac or rasp | retory arrest | Approximata interval Batween |
| | | iMMEDIATE CAUSE (Final disease or condition | 2001-1 | | ant | ate a | 2. | | Onset and Daath |
| - E - | | resulting in death) a. | meiasta | | | uc o | | | 343 |
| Z 2 2 2 2 | | | DUE TO (OR AS A | CONSEQUENCE OF | F)\d | | | | |
| | <u> </u> | Sequentially list conditions, if any, leading to immediate | | | | | | | |
| | \forall | cause. Entar UNDERLYING CAUSE (Disease or injury | | | | | | | |
| P.O. E th certifical ending phy Hygiene p | ᄩ | that initiated events resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF | F): | | | | |
| P. Path cattending Half Hy | CERTIFICATION | d. | | | | | | | |
| IRDS, Interpretate and Mentall | CALO | | | | | | | | |
| R at the by and and | 1 6 | PART ii. Other aignificant conditions | contributing to death bu | ut not reaulting i | In the underlying | g causa given in | | | 24b. WERE AUTOPSY FINDINGS |
| O = 8 = 8 | | PART ii. Other aignificant conditiona | contributing to death bu | ut not reaulting | In the underlying | g causa given in | PERFOR | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| O = 8 = 8 | MEDI | PART II. Other aignificant conditions | contributing to death be | ut not reaulting i | In the underlying | g cauaa given In | | RMED? | AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? |
| RECO requires the been signed t. of Health shows as | MEDI | DID TOBACCO USE CONTRI | | | | | PERFOR 1 YES 2 | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| TAL RECO The law requires the has been signed ate Dept. of Health | MEDI | DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL | IBUTE TO CAUSE OF | | S NO [| | PERFOR 1 YES 2 | RMED? | AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? |
| TAL RECO The law requires the has been signed ate Dept. of Health | SICIAN: MEDI | DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | BUTE TO CAUSE OF | F DEATH YE | ES NO TH (Check only one) OTHER: 4 Nursing Hom | | PERFOF | RMED? | AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? |
| OF VITAL RECO PHYSICIAN: The law requires the first certificate has been signed with the State Dept. of Health feed. or Item 23 shows at | IYSICIAN: MEDI | DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | BUTE TO CAUSE OF | F DEATH YE 26. PLACE OF OEAT etlent 3 □ DOA 28b. TIM | ES NO L TH (Check only one) OTHER: 4 Nursing Hom E OF 28c. INJ WO | UNCERTAIN to 5 Reeldence | PERFOF | RMED? | AMALLABLE PRIOR TO COMPLETION DE CAUSE OF DEATH? 1 YES 2 NO |
| OF VITAL RECO PHYSICIAN: The law requires the secretificate has been signed with the State Dept. of Health sed. or Item 23 shows at | BY PHYSICIAN: MEDI | DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | IBUTE TO CAUSE OF HOSPITAL: Inpatient 2 ER/Output (Month, Day, Year) | F DEATH YE 28. PLACE OF OEAT etlent 3 DOA 29b. TIM | ES NO FINANCIAL NO | UNCERTAIN 10 5 Reeldence UNITY AT INKY YES 2 NO | PERFOR 1 YES 2 8 Other (Specify) 28d. DESCRIBE HOW I | NO NO | AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO |
| OF VITAL RECO PHYSICIAN: The law requires the first certificate has been signed with the State Dept. of Health feed. or Item 23 shows at | TED BY PHYSICIAN: MEDI | DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | BUTE TO CAUSE OF | F DEATH YE 26. PLACE OF OEAT etient 3 □ DOA □ 26b. TIMI INJ — At home, term, a | ES NO FINANCIAL NO | UNCERTAIN 10 5 Reeldence UNITY AT INKY YES 2 NO | PERFOR | NO NO | AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO |
| DIVISION OF VITAL RECO DR ATTENDING PHYSICIAN: The law requires th DIRECTOR: After this certificate has been signed nours after death with the State Dept. of Health item 28 is marked. or item 23 shows at | ETED BY PHYSICIAN: MEDI | DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not ba determined | BUTE TO CAUSE OF A STATE OF THE PROPERTY OF TH | F DEATH YE 26. PLACE OF OEAT atlent 3 □ DOA □ 28b. TIMI INJ — At home, term, a | FM (Check only one) OTHER: 4 Nursing Hom E OF URY M 28c. INJ WO 1 1 | UNCERTAIN THE S Reeldence THE S REELDENCE THE S REELDE | PERFOR 1 YES 2 8 Other (Specify) 28d. DESCRIBE HOW 8 City or Town, State) | NJURY OCCUR | AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO |
| DIVISION OF VITAL RECO TAL DR ATTENDING PHYSICIAN: The law requires that DIRECTOR: After this certificate has been signed. The hours after death with the State Dept. of Health II Item 28 is marked, or them 23 shows at | MPLETED BY PHYSICIAN: MEDI | DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not ba datermined 29e. CERTIFIER (Check only) 1 CERTIFYING PHYSICI. | BUTE TO CAUSE OF A STATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Special Ant: To the best of my knowle | F DEATH YE 26. PLACE OF OEAT etient 3 DOA 29b. TIMI iNJ — At home, term, a | FIN (Check only one) OTHER: 4 Nursing Hom E OF WO 1 Nursing Hom attreet, fectory, office | UNCERTAIN 10 5 Residence 10 10 17 AT 17 IRK7 17 YES 2 NO 10 end plece, and due | PERFOR 1 YES 2 8 Other (Specify) 28d. DESCRIBE HOW I City or Town, State) | NJURY OCCUR | AMALLABLE PRIOR TO COMPLETION DE CAUSE OF DEATH? 1 YES 2 NO NO Review Route Number, |
| DIVISION OF VITAL RECO TAL DR ATTENDING PHYSICIAN: The law requires that DIRECTOR: After this certificate has been signed at house after death with the State Dept. of Health II Item 28 is marked, or Item 23 shows an | MPLETED BY PHYSICIAN: MEDI | DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not ba datermined 29e. CERTIFIER (Check only) 1 CERTIFYING PHYSICI. | BUTE TO CAUSE OF A STATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Special Ant: To the best of my knowle | F DEATH YE 26. PLACE OF OEAT etient 3 DOA 29b. TIMI iNJ — At home, term, a | FIN (Check only one) OTHER: 4 Nursing Hom E OF WO 1 Nursing Hom attreet, fectory, office | UNCERTAIN 10 5 Residence 10 10 17 AT 17 IRK7 17 YES 2 NO 10 end plece, and due | 8 Other (Specify) 28d. DESCRIBE HOW I 28f. LOCATION (Street City or Town, State) to the cause(e) and mer | NJURY OCCUR | AMALLABLE PRIOR TO COMPLETION DE CAUSE OF DEATH? 1 YES 2 NO NO Rural Route Number, |
| DIVISION OF VITAL RECO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires the FUNEAL DIRECTOR: After this certificate has been signed flied within 72 hours after death with the State Dept. of Health PORTANT: If Item 28 is marked, or Item 23 shows at | BE COMPLETED BY PHYSICIAN: MEDI | DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | BUTE TO CAUSE OF A STATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Special Ant: To the best of my knowle | F DEATH YE 26. PLACE OF OEAT etient 3 DOA 29b. TIMI iNJ — At home, term, a | FIN (Check only one) OTHER: 4 Nursing Hom E OF WO 1 Nursing Hom attreet, fectory, office | UNCERTAIN 10 5 Residence URY AT IRK? YES 2 NO e end plece, and due leath occured at the | 8 Other (Specify) 28d. DESCRIBE HOW I 28f. LOCATION (Street City or Town, State) to the cause(e) and mer | NJURY OCCUR | AMALLABLE PRIOR TO COMPLETION DE CAUSE OF DEATH? 1 YES 2 NO NO Review Route Number, |
| DIVISION OF VITAL RECO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires the FUNERAL DIRECTOR: After this certificate has been signed filled within 72 hours after death with the State Dept. of Health PORTANT: If Item 28 is marked, or Item 23 shows an | BE COMPLETED BY PHYSICIAN: MEDI | DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | BUTE TO CAUSE OF A STATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Special Ant: To the best of my knowle | F DEATH YE 28. PLACE OF OEAT etient 3 □ DOA 28b. TIMI INJ — At home, term, a | FIN (Check only one) OTHER: 4 Nursing Hom E OF URY M 28c. INJ URY M 1 1 | UNCERTAIN 10 5 Residence URY AT IRK? YES 2 NO e end plece, and due leath occured at the | 8 Other (Specify) 28d. DESCRIBE HOW I 28f. LOCATION (Street City or Town, State) to the cause(e) and mer | NJURY OCCUR | AMALLABLE PRIOR TO COMPLETION DE CAUSE OF DEATH? 1 YES 2 NO NO Rural Route Number, |
| DIVISION OF VITAL RECO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires the FUNEAL DIRECTOR: After this certificate has been signed flied within 72 hours after death with the State Dept. of Health PORTANT: If Item 28 is marked, or Item 23 shows at | BE COMPLETED BY PHYSICIAN: MEDI | DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | BUTE TO CAUSE OF A STATE OF THE | F DEATH YE 26. PLACE OF OEAT etilent 3 DOA 28b. TIMI iNJ | FIN (Check only one) OTHER: 4 Nursing Hom E OF URY M 28c. INJ URY M 1 1 | UNCERTAIN 10 5 Residence URY AT IRK? YES 2 NO e end plece, and due leath occured at the | 8 Other (Specify) 28d. DESCRIBE HOW I 28f. LOCATION (Street City or Town, State) to the cause(e) and mer | NJURY OCCUR | AMALLABLE PRIOR TO COMPLETION DE CAUSE OF DEATH? 1 YES 2 NO NO Rural Route Number, |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Durs after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

| | Item#1.18.19.b | G-film | 715 pe | r P.H | 9/9/ | 94 F | PC. | | | | | | |
|-------------|---|----------------------|--------------------|-------------------|--------------|-----------------------|---------------------|----------|-----------|------------------------|--------------|----------------------|--|
| | 1 - STATE REGISTRAR | STATE OF I | | D / DEPAR | | | | | MENTA | NL HYGIENI REG. NO. | E 9. | 4-2 | 6429 |
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | _ 01 | DEAI | - | 2. DAT | E OF DEATH | | 1 13 | PURS OF IDE |
| 1 | MARY A MCKEEVER | Mary A | ope1bv | Mckee | ver | | | | SE | PT. 07 | | 994 | 3 · 35 ∆M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yo | s. last birthday) | IF UNDER | | IF UNDER | | 7. DATE | OF BIRTH | Ť | 8. BIRTHPL | ACE (State or Foreign |
| 1 1 | 212-30-7106 | 1 ☐ M 2 🂢 F | 61 | YRS. | MONTHS | DAYS | HOURS | MIN. | Apr | . 03, 1 | 933 | Country) Mary | land |
| | 9a. FACILITY NAME (If not institution, give st | | | | 9b. CITY | , TOWN C | OR LOCATIO | ON OF DE | | | | TY OF OEAT | |
| O. | JOHNS HOPKINS HO | SPITAL | | | В | ALTI | MORE | CI | TY | | | N/A | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | | 10c CIT | Y, TOWN C | OR LOCAT | ION | | | | | 1 40 | Dd. INSIDE CITY |
| I E | Maryland Balt | imore | | 100.01 | Cub | | | | | | | | LIMITS? |
| | 10e. STREET AND NUMBER | Imore | | | Cub | | . ZIP CODE | | | | 10a, CITIZ | | YES 2 X NO |
| FUNERAL | 9105 Topwood Co | urt | | 21234 | | | | | | | SA | | |
| S | 11. MARITAL STATUS | 12. WAS DECEOEN | T EVER IN U.S | ARMED | 13. | WAS DEC | ENDENT O | F HISPAN | IC ORIGI | IN? (Specify Yas | | 14. RACE - | - American Indian, |
| BY F | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? I | YES 2 WAR OR DATES | ĭ∑ NO | | | ecify Cuba | | | Rican, etc.) | | Black, V Specify: | White, alc. |
| | | | | | | | | | | | | . , | White |
| 핕 | 15. DECEDENT'S EDUC (Specify only highest grade | | 164 | (Give kind of | work done | CCUPATIO during mo | ON ast of workin | g | 16 | b. KIND OF BUS | INESS/IND | USTRY | |
| " | Elementary/Secondary (0-12) | College (1-4 or 5 | 1 / | life. Do NOT u | | | | | | 77.1 | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | secreta | ary | | 10 MOTI | en'e NA | AE /Einst | Educa | | | |
| m CC | Otto E. Appleby | | | | | | | | | Middle Maiden | | | |
| 00 | 19a. INFORMANT'S NAME (Type/Print) | | | 19b. MAILING | ADDRESS | S (Street a | | | | | | Code) | |
| 임 | 19a. INFORMANT'S NAME (Type/Print) Mariellen Angelo 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Forest 4010 Forest Valley Road, Baltimore, MD 212 | | | | | | | | | 21234 | | | |
| | | | | | | | | | | | | | |
| | 4 Donation 3 Other (Specify) St. John's Church Cem. Hydes, MD | | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE/LIC | ERISEE | NIL | | | | ND ADDRES | | | Wiedefe | 1.1 | Tno | |
| | Bryan W. Clar | y .Cla | 140 |) | | | | | | ., Timo | - | | 21093 |
| | 23. PART i. Enter the elseeses, or c shock, or heart fallure. I | omplications the | coused the | e deeth. Do | not enter | the mo | de of dyl | ng, auch | n as cei | rdlec or reapli | atory arm | eat, | Approximate |
| | IMMEDIATE CAUSE (Fine) | de oneacu | in integral | | | | | | | Onset and Death | | | |
| | disease or condition resulting in death) | SYND NSEQUENCE O | rome | 2 | | | | | | | 4 days | | |
| | | (OR AS A CO | NSEQUENCE O | F): | | | | | | | | 0 | |
| NO NO | Sequentially list conditions, Gall-blacker Cancer | | | | | | | | | unknown | | | |
| RTIFICATION | if any, leading to immediate cause, Enter UNDERLYING | | | | | | | | | | | | |
| [윤] | CAUSE (Disease or injury that initiated events | DUE TO | (OR AS A CO | NSEQUENCE O | F): | | | | | | | | |
| ERTI | resulting in deeth) LAST | 1 | | | | | | | | | | | |
| O | DART ii Other significant condition | | denak bila | | | | | | | | | _ | |
| MEDICAL | PART ii. Other eignificent condition | e contributing to | deeth but r | ot resulting | in the un | aderiyini | g ceuse g | iven in | Part I. | 24a. WAS AN | | AN. | ERE AUTOPSY FINDINGS MILABLE PRIOR TO |
| | | | | | | | | | _ | 1 TYES 2 | XNO. | | OMPLETION OF CAUSE F DEATH? |
| | DID TOBACCO USE C | ONTRIBUTE | TO CA | USE OF | DEAT | H YI | ES 🗀 | NO | X | | | 1 | ☐ YES 2 NO |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | | DUAL | | ACE OF D | | _ | one) | | | |
| PHYSICIAN | EXAMINER? 1 YES 2 KNO | HOSPITAL: | ER/Outpetler | nt 3 DOA | OTHER | R: | | | | er (Specify) | | | |
| Ě | 27. MANNER OF DEATH | 20a. DATE OF | INJURY | 26b. TIN | E OF | 28c. INJ | URY AT | arounca | | SCRIBE HOW IN | JURY OCC | URED | |
| ВУР | 1 Natural 5 Pending 2 Accident Investigation | Notappi | | IN. | JURY M | | PRK7 YES 2 |] NO | | | | | |
| | 3 Suicide 6 Could not be | 26s. PLACE C | | At home, ferm, | streel, fact | tory, offic | a | | 261. LO | CATION (Street a | nd Number | or Rural Rou | te Number, |
| ETE | 4 Homicide detarmined | | , ap 3011y) | | | | | | On) | y or Town, State) | | | |
| PLE | 29a. CERTIFIER 1 CERTIFYING PHYSIC | CIAN: To the best of | my knowledg | a, daath occum | ed at the t | lme, data | and placa, | and dua | to the co | euse(a) and man | ner as state | ıd. | |
| COMPL | | | | | | | | | | | | | nd manner as stated, |
| l w | 296. SIGNATURE AND TITLE OF CERTIFIER | | | | | | 29c. LICE | NSE NUM | IBER | | 29d. DATE | SIGNED (M | fonth, Day, Year) |
| 8 | Comment | M.D. | | | | | 10 | 1300 | | | | 0/1/04 | 1 |

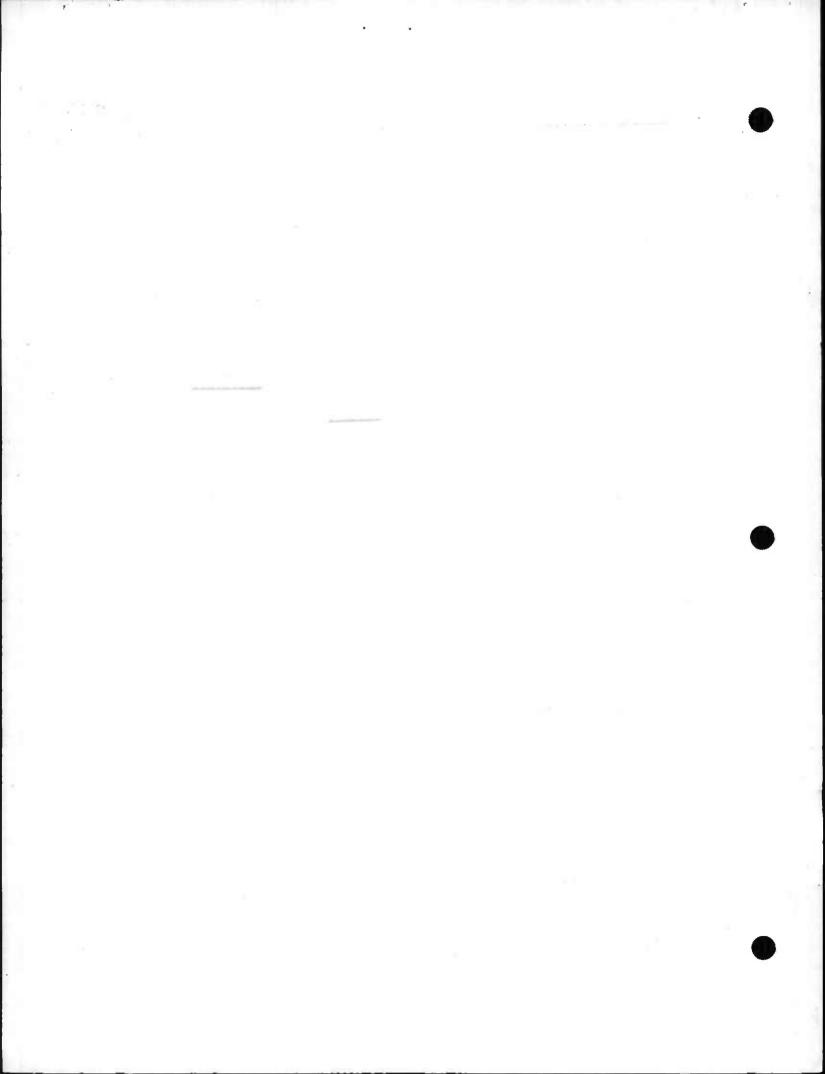
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

JOHNS

71 DATE FILED (MONTH, Day, Yolf)
SEP - 9 1994

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BALTIMORE



DNMH-16 Rev 1/89

| 020 | nospital or attending physician |
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| 215-0 | aftending |
| BALTIMORE, MARYLAND 21215-0020 | hospital or |
| YLA | by the |
| MAR | Page 6 may be retained by the ho |
| Ä, | пау ре |
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| ALT | her death. F |
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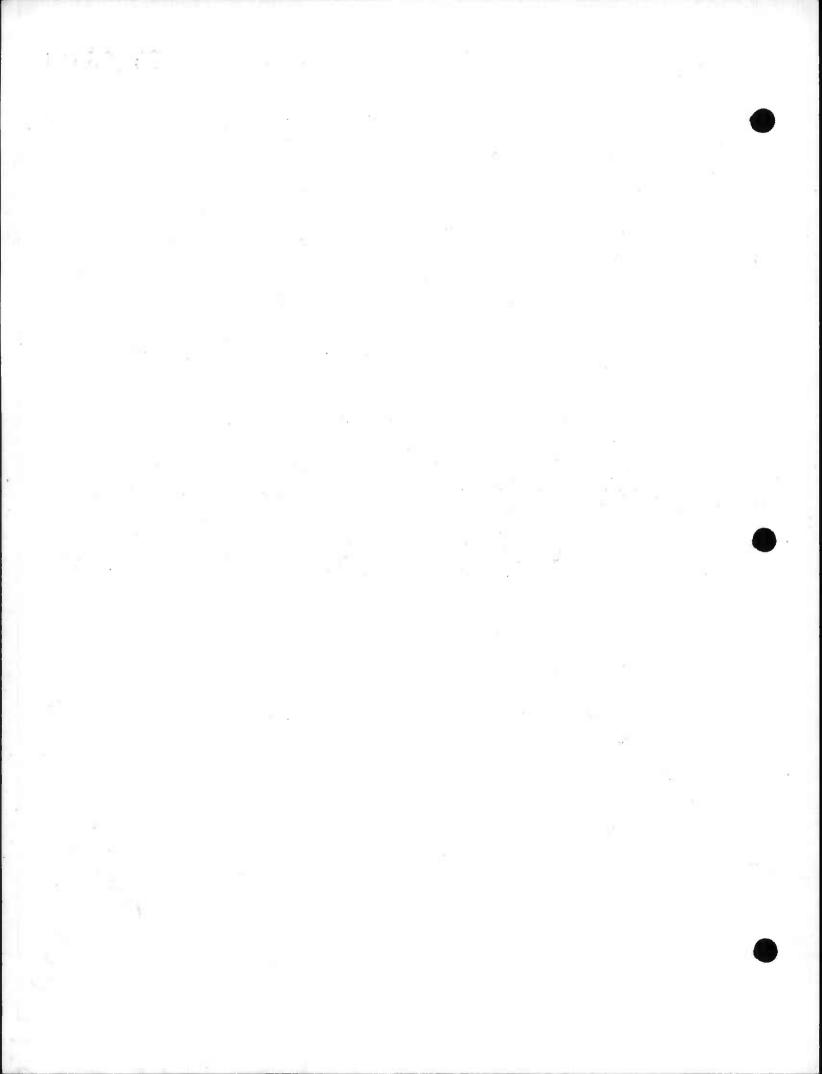
| | 1 - STATE REGISTRAR | STATE OF MARYL | | MENT OF H | | | GIENE | | |
|---------------|---|---|--|---|---|--------------------------------|---|-------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | Mercer | | | | 2. DATE OF DE | DAY | YEAR | 3. TIME OF DEATH 3:35 A |
| | 4. SOCIAL SECURITY NUMBER 220-07-7007 9a. FACILITY NAME (II not institution, give | 5. SEX 6. AGE (| 7 9 YRS. | F UNDER I YEAR MONTHS DAYS 9b. CITY, TOWN C | IF UNDER 24 HRS. HOURS MIN. DR LOCATION OF D | 7. DATE OF BIF (Month, Den. | TIN I | 8. BIRTH | IPLACE (State or Foreign |
| CTOR | Bon Secours Hospital Balto. City Md. RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND BALTIMORE CITY | | | | | | | | |
| | MARYLAND 10b. COUNT | тү | BALTIMORE CITY | | | | | | 10d, INSIDE CITY LIMITS? t PES 2 NO |
| FUNERAL | HARBOR CITY NURSI | NG HOME | IG HOME UNKNOWN | | | tog. CITIZER | | | WHAT COUNTRY? |
| B | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? t YES IF YES, GIVE WAR OR DA | DENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— 14 YES 2 NO 15 yes, specify Cuban, Maxican, Puerto Rican, etc.) | | | | | 14. RACE Black Special BLA | |
| ETED | ts. DECEDENT'S ED (Specify only highest grad Elementery/Secondary (0-12) | (Give kind of wo | DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | | | |
| COMPL | PRIMARY SCHOOL 17. FATHER'S NAME (First, Middle, Last) | Omege (14 of 54) | BARBER/LABORER | | | | SUBWAY BARBER SHOP | | |
| ш | JOSEPH | MERCER | | | 18. MOTHER'S NAME (First, Middle, Meid ANNIE | | | PORTER | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) CLARENCE | MERCER | | | | | or Town, State, Zip (| | 216 |
| | 20a. METNOD OF DISPOSITION 1 1 2 Burlel 2 Cremetion 3 Rer 4 Donetion 5 Other (Specify) | · 20b | PLACE AND DATE OF DELETY, CREMETORY OF Oth | DISPOSITION (Na | me of | DATE | BALTIMORI | ity or To | wn, State |
| | 21. SIGNATURE OF FUNERAL SERVICE L | | | JOSEPH | H. BRO | WN JR. 1 | FUNERAL I | HOME | - |
| CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in daath) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in daath) LAST | B. DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A d. | consequence of: | strad | tima p | Sanne | | | Approximate interval Batwee Onset and Deat M Institute days |
| MEDICAL CI | PART II. Other significant condition | | | | | 10 | WAS AN AUTOPSY ERFORMED? YES 2 NO | 24b. | . WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO |
| 'SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | ACE OF DEATH (C) | | | | |
| PHYSI | t V66 2 NO 27. MANNER OF DEATH | 1 Impettent 2 ER/Outp. 28e. DATE OF INJURY | atient 3 DOA 4 | OF 28c, INJ | 5 Residence | | HOW INJURY OCCU | URED | |
| ВУ Р | t Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJUI | M t 🗆 Y | ES 2 NO | | | | |
| Œ | 3 Suicide 8 Could not be 4 Nomicide determined | 28s, PLACE OF INJURY building, etc. (Spec | - At home, lerm, atr | reet, tectory, office | | 281. LOCATION City or Town | (Street and Number of, State) | ir Rural A | loute Number, |
| MPL | | SICIAN: To the best of my knowl IER: On the bests of examination | | | | | | | e) end menner as stated. |
| BE CO | 29b. SIGNATURE AND TITLE OF CERTIFIE | ER . | | | 29c. LICENSE NUI | | 29d, DATE | SIGNED | (Month, Day, Year) |
| 10 | 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CAUSE OF DE | • ATH (ITEM 27) (Type. F | Print) | 04323 | 5 | 1 9 | 15 | 7/94. |
| | St. DATE FILED (Month, Day, Year) | boud 1. | 0 | | econy | s Ihis | rital | Magne | |
| | SEP 0 9 1994 | Inti Danien-1 | Russell | | | | | | |

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BALTIMORE, MARYLAND 21215-0020

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| DIVISION OF VITAL RECORDS, P.O. B | fic | 췹 | 9 |
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| | TO THE HOSPING OR ATTENDING PHYSICIAN: The law requires that the death certificate | TO THE FUNDAL AND THE ACTION of this certificate has been signed by the attending phys | be filed with the hours are eath with the State Dept. of Health and Mental Hygiene pr |
| | 12 | 12 | 8 |
| | | | |

| | | | | | | | | | | 26431 | | |
|--|----------|---|--|--|--|---|--|--|--|---|--|--|
| _ | _ | FOR STATE REGISTRAR | STATE OF N | MARYLAND | / DEPAR | RTMENT O | F HEALTH AND N OF DEATH | MENTAL HYGIEN REG. NO | | | | |
| | i | | ZINA | IDF | 4 | Mus | MAN | 2. DATE OF DEATH MONTH | × 9 | YEAR 3. TIME OF DEATH | | |
| | | 4. SOCIAL SECURITY NUMBER 219-25-5600 | 5. SEX | 6. AGE (In yrs. | - | IF UNDER 1 YE | | 7. DATE OF BIRTH (Month, Day, Year) AUG. 19, | | 8. BIRTHPLACE (State or Foreign Country) 3. RUSSIA | | |
| " | | 9a. FACILITY NAME (If not institution, give : | street and number) | | | 9b. CITY, TO | WN OR LOCATION OF DE | | | TY OF DEATN | | |
| 1 2 | 5 | NORTHWEST HOSPITAL CENTER RESIDENCE OF DECEDENT | | | | RANDALLSTOWN | | | | BALTIMORE | | |
| DIRECTOR | - 16 | | TIMORE | | 10c. CIT | OWIN | GS MILLS | | | 10d. INSIDE CITY LIMITS? 1XXYES 2 \(\square\) NO | | |
| FUNERAL | 5 | 100. STREET AND NUMBER 841 JOSHUA TREE | COURT | | | | 101. ZIP CODE 21117 | | 10g. CITIZ | EN OF WHAT COUNTRY? | | |
| 2 | | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. | ARMED | 13. WAS | DECENDENT OF NISPAN | IC ORIGIN? (Specify Ye | e or No- | USA 14. RACE — American Indian, | | |
| \ \a | | 1 Never Married 2 Married FORCES? 1 YES 3 Awdowed 4 Divorced IF YES, GIVE WAR OR DATE | | | 2 NO If yes, specify Cuben, Mexican, Puerto Rican, etc.) | | | | | | | |
| ETED | | 15. DECEDENT'S EDU (Specify only highest grade | | .18a. | OECEDENT'S (Give kind of life. Do NOT u | USUAL OCCUI | PATION g most of working | 16b. KIND OF BL | SINESS/INDU | STRY | | |
| | | Elementary/Secondary (0-12) | College (1-4 or 5 + | •) | MINE. DO NOT U | TEACH | ER | E | DUCATI | ON | | |
| COMPL | | 17. FATNER'S NAME (First, Middle, Last) | | | | | | ME (First, Middle, Maider | | | | |
| ed al |) r | YURT GOLDBERG 19a. INFORMANT'S NAME (Type/Print) | | 10h MAII INC | Annese (se | KATI | | un Chair Wo / | 2-4-1 | | | |
| examiner must be notified at once. | <u>'</u> | MRS. LILA FOKSHA | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 841 JOSHUA TREE CT. OWINGS MILLS, MD 21117 | | | | | | | | |
| must b | i | 20a_METHOD OF DISPOSITION 1 | | | | | | | | | | |
| luer | 1 | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. SOLAN LEPPENSONCILLY BROS., INC. | | | | | | | | | | |
| | | | | | | | | TOWN RD B | ALTIMO | DRE,MD 21215 | | |
| nedica | | shock, Dr./heart failfure. | complications that List only one ceu | t caused the | death. Do ine. | not enter the | mode of dying, auch | as cardiac or reap | iratory erre | Interval Between | | |
| the the | | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Onset and Death | | | | | | | | | | |
| E S | | Todattily in boatily | DUE TO | | | | | | | | | |
| 9 | | | A . | | SEQUENCE O | F): | ROCA | CT CA | NICE | FR | | |
| umatic e | | Sequentially list conditions, if any, leading to immediate | · MET | OR AS A CON | AT | 10 | BREA | ST CA | NCE | 5R | | |
| er traumatic e | | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | b. METO | (OR AS A CON | SEQUENCE O | TC Fi | BREA | ST CA | NCE | ER | | |
| or other traumatic event, the medical | | if any, leading to immediate cause. Enter UNDERLYING | b. METO | TZA | SEQUENCE O | TC Fi | BREA | ST CA | NCO | ER | | |
| 5 5 | | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | b. DUE TO | (OR AS A CONS | SEQUENCE O | f): | | Part I. 24a, WAS AI | AUTOPSY | 24b. WERE AUTOPSY FINDING | | |
| any injury, | | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | b. DUE TO | (OR AS A CONS | SEQUENCE O | f): | | | AUTOPSY | | | |
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| RTANT Nam 2014 marked, or item 23 shows any injury, E COMPLETED BY PHYSICIAN: MEDICAL CE | | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificent condition DID TOBACCO USE (25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Create only one) 2 MEDICAL EXAMINER | b. DUE TO C. DUE TO d | (OR AS A CON: (OR AS | SEOUENCE O SEOUENCE O SEOUENCE O Ot resulting USE OF 28b. Till IN. home, term, death occurr for investigation | DEATH 2 OTHER: 4 Nursing BE OF 28cd JURY M 1 street, fectory, on, in my opinic | YES NO B. PLACE OF DEATH (Che Nome 5 Residence INJURY AT WORK? YES 2 NO Office data and place, and due on, death occurred at the 29c. LICENSE NUM | Part I. 24e. WAS AI PERFO 1 YES Ck only one) 5 Other (Specify) 28d. DESCRIBE NOW 28f. LOCATION (Street City or Town, State to the cause(a) and mailine, data and place, e | INJURY OCCL and Number of the dua to the 29d. DATE | 24b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO JRED JRED d. cause(s) and manner as stated. | | |
| IPORTANT: New 2014 marked, or item 23 shows any injury, BE COMPLETED BY PHYSICIAN: MEDICAL CE | | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificent condition DID TOBACCO USE (25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 29 Accident Investigation 3 Suicide 8 Could not be detarmined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIE | DUE TO C. DUE TO d. The contributing to CONTRIBUTE HOSPITAL: 1 Inpetient 2 28e. DATE OF (Month, D) 28e. PLACE O building. ICIAN: To the best of an ICIAN: To the | (OR AS A CON: (OR AS | SEOUENCE O SEOUENCE O SEOUENCE O Tesulting USE OF 28b. Till IN. home, term, death occurr for investigation TEM 27) (Type | DEATH DEATH OTHER: 4 Nursing E OF 28c JURY M 1 street, factory, ed at the time, on, in my opinic | YES NO B. PLACE OF DEATH (Che Nome 5 Residence INJURY AT WORK? YES 2 NO Office data and place, and due on, death occurred at the 29c. LICENSE NUM | Part I. 24e. WAS AI PERFO 1 TYES Ock only one) 5 Other (Specify) 28d. DESCRIBE NOW 28f. LOCATION (Street City or Town, State to the cause(s) and mailme, data and place, e | INJURY OCCL and Number of the dua to the 29d. DATE | 24b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO JRED JRED d. cause(s) and manner as stated. | | |



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CERTIFICATE OF DEATH

IF UNDER 1 YEAR IF UNDER 24 HRS.

HOURS

DAYS

SEP

(Month, Day,

Joseph Melman

6. AGE (In yrs. last birthday)

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

Molmor

14 4737

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215 permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH 01 Baltimore Baltimora DIRECTOR Sinai RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION BALTIMORE 10a. STATE 10b. COUNTY MARYLAND 101. ZIP CODE 21210 FUNERAL 10a. STREET AND NUMBER 1190 W. NORTHERN PKWY, APT. 429 by the hospital or attending physician. be detached for use as the burial-transit 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Maxican, Puerto Rican, etc.)
1 YES 2 X Specify: 12. WAS DECEDENT EVER IN U.S. ARMED BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Merried 2 Married В 3 Widowed 4 Divorced IIWW 15. DECEDENT'S EDUCATION (Specify only highest grade according COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) AUDITOR 5+ 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) TE. Page 6 may be retained by ANNA MELMAN BE RENITAMIN notified 19a. INFORMANT'S NAME (Type/Print) 196 MAILING ADDRESS (Street and Murcher of Burnel Bourto Apple, City 229", BRAZTIMORE, MD 21210 2 MRS. SHIRLEY MELMAN 9 20a. METHOD OF DISPOSITION
1 X Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must funeral director, HEBREW YOUNG MENS-9-8-94 4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY death. SOL LEVINSDON & BROS., INC. d completely filled in by the full viral, cremation, or removal. 6010 REISTERSTOWN RD BALTIMORE, MD 21215 medical 4. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, affure. List only one cause on sech line. shock, or heart fally IMMEDIATE CAUSE (Final the disease or condition Acute Tubu event, resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF) and control Acute traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): 0 attending physician tal Hygiene prior to 8 Diabetic cause. Enter UNDERLYING Nephropat CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in deeth) LAST Sersis 6 the atten PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL thealth and N any AKA shows a Diabetic Retinopathy 1/x MI

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\sigma \) NO \(\sigma \) ICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item EXAMINER? certificate to the State HOSPITAL PHYSI 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 10 the 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? marked. this c 1 Natural 5 Pending 1 YES 2 NO В After 1 Investigation ATTENDING 2 Accident 3 Sulcide 28e. PLACE OF INJURY — At home, term, street, factory, office building, stc. (Specify) 9 4 Homicide detarmined DA 29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. COMPL MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HO TO THE FU De filed 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE Curoli, Do, Intern 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Intern Crock Sinai SEP - 9 1994 32. REGISTRAR'S SIGNATURE Studen Re

94 26432 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2. DATE OF DEATH MONTH 3. TIME OF DEATH 920 A M 05 8. BIRTHPLACE (State or Foreign Country) 7. DATE OF BIRTH 01,1922 PENNSYLVANIA 9c. COUNTY OF DEATH Ballimore 10d. INSIDE CITY 1 YES 2 | NO 10g. CITIZEN OF WHAT COUNTRY? USA 14. RACE — American Indian, Black, White, etc. Specify: WHITE 16b. KIND OF BUSINESS/INDUSTRY STATE OF MARYLAND KLAWANSKY 20c. LOCATION -- City or Town, State BALTIMORE, MD interval Between Onset and Deeth 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 TYES 2 YO NO 1 - YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29d. DATE SIGNED (Month, Day, Year)

05 SEP 94

N N

| BALTIMORE, MARYLAND 21215-0020 | cours after death. Page 6 may be retained by the hospital or attending physician. | DIRECTOR And this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should have a summer or the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | medical examiner must be notified at once. |
|--|--|---|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | AN ATTENDED PHYSICIAN: The law requires that the death certificate be executed within. Fours after death, Page 6 may be retained by the hospital or attending physician. | DIPPORTE AT THIS CERTIFICATE has been signed by the attending physician and completely fills community that the State Dept. of Health and Mental Hygiene prior to burial, cremation, | Nam 25 immarked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1 - STATE REGISTRAR | STATE OF MARYL | CERTIFIC | | | NTAL HYGIEN | | |
|------------------------------------|--|---|--|--|---|---|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | 7112 01 | | DATE OF DEATH | | 3. TIME OF DEATN |
| | | PAUL | MIDDLETO | NC | 5 | SEPT. 7 | 94 | 8:38 Am |
| - 9 | | | 944 | FUNDER 1 YEAR | HOURS MIN | DATE OF BIRTN (Month, Day, Year) | Count | IPLACE (State or Foreign |
| | 212-52-3565 9e. FACILITY NAME (If not institution, give street | ¹ X ^{M 2} □ F 43 | YRS. | 1070 | l l | NOV.18,19 | 50 MAR | ŸLAND |
| Œ | 816 NORTH CHAPI | et end number) ELGATE LAN | | | ORE CITY | | 9c. COUNTY OF D | EATN |
| DIRECTOR | RESIDENCE OF DECEDENT | | | | | | | |
| 2 | 10a. STATE 10b. COUNTY | | toc. CITY, T | OWN OR LOCAT | TION | | | 10d. INSIDE CITY LIMITS? |
| | MARYLAND 100, STREET AND NUMBER | | | | LTIMORE | | | 1 X YES 2 NO |
| FUNERAL | 816 N. CHAPEL GATE | TANE | | 101 | 21229 | | 10g. CITIZEN OF V | |
| S | | 2. WAS DECEDENT EVER IN | U.S. ARMED | 13. WAS DEC | ENDENT OF NISPANIC | ORIGIN? (Specify Yes | U.S. | A . E — American Indian, |
| BY F | 1 Never Married 2 Merried 3 Widowed 4 Divorced | FORCES? 1 YES | 2 NO | If yes, sp | ecify Cuban, Maxicen, P 2 V NO Specify: | | Blaci | k, White, etc. |
| | | | | | | | | WHILE |
| | 15. DECEDENT'S EDUCA (Specify only highest grade co | mpleted) | (Give kind of work life. Do NOT use re | done during mo | ON ist of working | 16b. KIND OF BUS | INESS/INDUSTRY | |
| PL | | College (1-4 or 5 +) YRS | CULIN | , | | RESTAU | RANT | |
| COMPLETED | 17. FATNER'S NAME (First, Middle, Last) | | - | | 18. MOTHER'S NAME | | | |
| BE (| JULIAN A. MIDDLETON | <u>N</u> | | | MARIE D. | LAWLER | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | and Number or Rural Rout | | | |
| | CELESTE MIDDLETON 20a, METHOD OF DISPOSITION | | | | STREET - | | | 1202 |
| | 1 Buriel 2 XCremation 3 Remove | | PLACE AND DATE OF C letery, cremetory or other SREENMOUNT | | | | CATION — City or To | wn, Slata |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | | RELATIOUNI | 22. NAME AP | D ADDRESS OF FACILI | TY | TIMORE | |
| | Dackie N. | Shanne | 2 | 1 | RD FUNERAL | • | | |
| | 23. PARTY. Enter the disesses, pr cor | mplications that caused | I the death. Do not | enter the mo | WILKENS AV | ENUE-BAL | TIMORE, I | Approximata |
| | shock, or heart fellure. Lis | st only one ceuse on e | ech Ilne. | | | | | Interval Batween Onset and Death |
| | disease or condition resulting in death) | CON | Tel Ge | rotel | thous | d to a | 051 | |
| | and the state of t | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | |
| NO NO | Sequentially list conditions, b. | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | |
| | If eny, lesding to immediate | 00E 10 (011 AB A | CONSEQUENCE OF J. | | | | | |
| 4 | csuse, Enter UNDERLYING | | | | | | | |
| IFICA | CAUSE (Disease or Injury that initiated events | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | |
| ERTIFICA | CAUSE (Disease or Injury C. | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | |
| L CERTIFICATION | CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | he underlying | g csuse given in Psr | t I. 24s. WAS AN | AUTOPSY 24b | WERE AUTOPSY FINDINGS |
| AL | CAUSE (Disease or Injury that initiated events | | | he underlying | g csuse given in Per | PERFOR | MED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| AL | CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | he underlying | g csuse given in Par | | MED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
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| COMPLETED BY PHYSICIAN: MEDICAL | CAUSE (Disease or Injury that Initiated events resulting in desth) LAST PART II. Other significant conditions of the co | BUTE TO CAUSE O HOSPITAL: Inpatient 2 ER/Outp 26a. DATE OF INJURY (Month, Day, Year) 26a. PLACE OF INJURY building, etc. (Spec | F DEATH YES 28. PLACE OF DEATH (28b. TIME O INJURY At home, term, stre- ify) added, death occurred a | Check only one) THER: Nursing Hom F 28c. INJ WO 1 1 1 | UNCERTAIN | Other (Specify) d. DESCRIBE HOW IN L. LOCATION (Street a. City or Toyre, State) the ceuse(a) end menia, dete and place, and | MED? NO NO NO NO NO NO NO NO NO N | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO Self-Roughe Number, He Carre (Month, Day, Year) |
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| COMPLETED BY PHYSICIAN: MEDICAL | CAUSE (Disease or Injury that Initiated events resulting in desth) LAST PART II. Other significant conditions of the co | BUTE TO CAUSE O HOSPITAL: Inpatient 2 ER/Outp 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Spec | The property of the property o | Check only one) THER: Nursing Hom F 28c. INI WO 1 1 N et, factory, office at the time, dete | UNCERTAIN | Other (Specify) d. DESCRIBE HOW IN L. LOCATION (Street as City or Keyn, State) the ceuse(s) end menue, dete and place, and | MED? NO NO NO NO NO NO NO NO NO N | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH'S South Number, the Carre of Cause o |

TO THE FUNER TO THE FUNER De filed within

172 6 . BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

The strain and the last the death certificate be executed within an ours after death. Page 6 may be retained by the hospital or attending physician.

The strain with the strain of the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL OR ATTENTO TO THE FUNERAL DIRECTOR TO THE FUNERAL DIRECTOR TO FILED WITHIN 72 hours after the states of the stat

| | 1 - STATE REGISTRAR | STATE OF I | / MARYLAND CE | | | OF DEA | | MENTA | REG. NO | | | |
|-----------------------|---|--|--|----------------|------------------|---|------------|------------------------|-------------------------------------|------------|------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, | Last) | | | MON | CUR | | 2. DATE MON' SEF | T O | 6 | year 94 | 3. TIME OF DEATN 9:42 A |
| g | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last | birthday) | | AYS HOURS | ER 24 HRS. | (Mon | E OF BIRTH | | Count | |
| | 9a. FACILITY NAME (If not institution, | | N/A | | 96. CITY, TO | WN OR LOCA | TION OF D | | -29-94 | 9c. COUR | TY OF D | |
| DIRECTOR | JOHNS HOPKIN | S HOSPITA | \L | | BALT | IMORE | CIT | ΓY | | 1 | NONE | <u> </u> |
| REC | 10e. STATE 10b. C | OUNTY | | 10c. CIT | Y, TOWN OR | | | | | | | 10d. INSIDE CITY |
| | MARYLAND 100. STREET AND NUMBER | NONE | | L | BAL | 'IMORI | | TY | | | | YES 2 NO |
| ERA | 1908 E. LAN | VALE STRE | ET | | | 10f. ZIP CO | 0E 2121 | 3 | | - | | WHAT COUNTRY? STATES |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | E000000 | TEVER IN U.S. ARM YES 2 X NOWAR OR DATES | MEO O | If y | S OECENDENT DE, specify Cut YES 2 | en, Mexico | an, Puarto | N? (Specify Yea Rican, etc.) | or No- | 14. RAC Blac RIC | E — American Indian, k, White, etc. |
| TED | 15. DECEDENT' (Specify only highes | | (Gh | en kind of a | USUAL OCCI | JPATION ng most of worl | kina | 16 | b. KIND OF BUS | SINESS/IND | USTRY | |
| COMPLETED | Elementary/Secondary (0-12) NONE | College (1-4 or 5 - NONE | | Do NOT us | nE | | urig | | | N | ONE | |
| S | 17. FATNER'S NAME (First, Middle, La | | | | | | | | Middle, Maiden | | | |
| BE | WILLIE MONC 198. INFORMANT'S NAME (Type/Print | | 196 | MAILING | AODRESS /S | | | | PINNI(| | 0.41 | |
| 2 | ANDREA PINN | | | | | | | | BALTO, | | | 1213 |
| | 20a. METHOD OF DISPOSITION Burial 2 Cremetton 3 | | 20b. PLACE A cemetery, cren | natory or o | ther placel | , | | DA | | CATION — | | |
| | 4 Donation 5 Other (Specify 21. SIGNATURE OF FUNERAL SERVI | | IKING | MEM | OR [A] | PARE ME AND ADDR | ESS OF FA | 10/ | 941 GRA | ANIT | Ε, Ι | MARYLAND |
| | · Cahin | B. Scr | رمهم | 4- | | | | | GGS FU | | | HOME TO.MD.2121 |
| CERTIFICATION | 23. PART I. Enter the disease abock, or heart fel iMMEDIATE CAUSE (Finel disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente reaulting in death) LAST | a. SUDDE DUE TO | ise on each line. | UENCE OF | DEATH FI: | | | | | | | Approximate Interval Between Onset and Death |
| PHYSICIAN: MEDICAL CE | PART II. Other algnificent con DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDIC | ONTRIBUTE TO CA | USE OF DEAT | TH YE | s 🗆 No | D UN | given in | | 24a. WAS AN PERFOR 1 YES 2 | IMED? | 246 | . WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| SICI | EXAMINER? | HOSPITAL: | ER/Outpatient 3 | | OTHER: | Home 5 🗆 F | anidana. | | an (Sanatha) | | | |
| PHY | 27. MANNER OF DEATN | 26s. DATE OF | INJURY | 26b. TIM | | c. INJURY AT WORK? | tesidenca | | SCRIBE NOW II | NJURY OCC | URED | |
| B | 1 Natural 5 Pending 2 Accident Investige | ntion | F INJURY — At hon | | M | YES 2 | □ NO | | | | | |
| TED | 3 Suicide 8 Could n 4 Nomicide determin | or by building. | etc. (Specify) | 100, 100/11, 1 | arreet, factory. | onica | | City | CATION (Street a or Town, State) | and Number | or Hural F | Route Number, |
| COMPLETED | | PHYSICIAN: To the best of AMINER: On the basis of ex | | | | | | | | | | a) and manner sa stated. |
| 띪 | 295 ESIGNATURE AND TITLS OF GE | Dille 7 | 4/ | | | | C.M | | | | | (Month, Day, Year) 7,1994 |
| \sim 1 | | 1 | 1101 | | | 0 • | - 9 7 7 | | | | | . 1 |
| 2 | WARIO + GOL | N WHO COMPLETED CAU | | | | Stree | et. | Balt | imore | . Ma | rvi | land 21201 |

urial-transit permit. Pages 1, 2, 3 should ohysician. BALTIMORE, MARYLAND 21215-0020

O. BOX 68760,

| DIVISION OF VITAL RECORDS, P. | TO THE HOSPITAL OR ATTENDING PAYSICIAN: The law requires that the death or | has been signed by the attendi | Dept. of Health and Mental Hy | IMPORTANT: If them 28 it marked or teem 23 shows any injury, or |
|-------------------------------|--|--------------------------------|--------------------------------|---|
| ON OF VI | DING PHYSICIAN: The | Ar this centicate | earn with the late | market or tem |
| DIVISIO | TO THE HOSPITAL OR ATTEND | TO THE FUNERAL DIRECTOR. | be filed within 72 hours after | IMPORTANT: If Item 28 A |
| , | | | | |

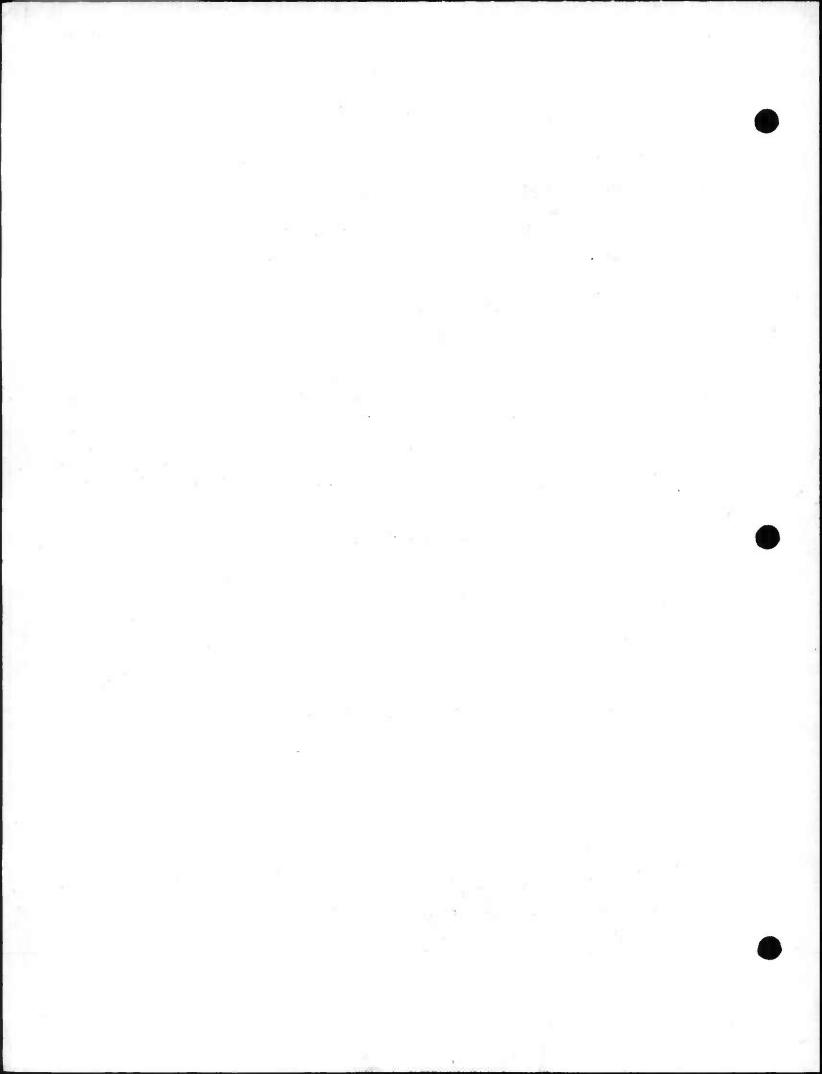
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| aversity. The law requires that the death certificate be executed within a rours after death. Page 6 may be retained by the hospital or attending I | ien cate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bi | | |
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| pit | P | | |
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| 9 | eta | | 5 |
| 5 | e d | | mined or tem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| É | tely | ear with the tate Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | ť, |
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| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENI |
|---|---------|
| CERTIFICATE OF DEATH | BEG NO |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTI | | | MENTAL | HYGIEN REG. NO. | E | | | |
|--------------|--|---|--|---------------------|---|---------------|-----------------------------------|-----------------|---------------------|---|--------------|
| | DECEOENT'S NAME (First, Middle, Last) A 1 | thur Chale | n Minor | | | MONTH | | | /EAR | E OF OEAT | |
| | 4. SOCIAL SECURITY NUMBER 215-09-9627 | | In yrs. last birthday) | F UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN, | 7. DATE C | 0 0 BIRTH 24/08 | | BIRTHPLACE Country) | (State or For | a M reign |
| H. | 9a. FACILITY NAME (If not institution, give 2716 Superior | atreet and number) Avenue | 9 | Balti | IN OTE | | 24700 | 9c. COUNT | 11ino | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | Y | 10c, CITY. | TOWN OR LOCAT | | | | Dall | imore | ISIDE CITY | |
| | Maryland Balt | imore | | | Baltin | nore | | | 1 🗆 1 | MITS? | No |
| FUNERAL | 2716 Superior | Avenue | | 101 | 2123 | 34 | | | N OF WHAT CO | OUNTRY? | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR OA | 2 NO | If yes, sp | ENDENT OF HISPA Icity Cuban, Maxici 2 NO Specia | an, Puerto Ri | (Specify Yee loan, etc.) | | Black, White | erican India | ın, |
| ETED | 15. DECEOENT'S EOU (Specify only highest grade Elementary/Secondary (0-12) | JCATION e completed) College (1-4 or 5 +) | 16a. OECEDENT'S US (Give kind of word life. Do NOT use r | k done during mo | N st of working | 16b. | KINO OF BUS | INESS/INOUS | | 1100 | |
| COMPLET | 12th 17. FATHER'S NAME (First, Middle, Last) | | Superin | tender | | | | | ng In | dust | ry |
| BE C | Ed Minor | | | | 18. MOTHER'S NA | | Mae Malden | | iams | | |
| 2 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | nd Number or Rural | Route Numbe | er, City or Town | , State, Zip Co | ode) | | \neg |
| | Mary E. Minor 200. METHOD OF DISPOSITION | 206 | 2716 S | | or Aven | ue B | _ | | MD 2 | | |
| | 1 □ Burlel 2 X Cremation 3 □ Ram 4 □ Donellon 5 □ Other (Specify) | ioval from State | etery, crematory or other | atory | Inc. | 09/0 | 8 Bal | ltimo | re, M | D | |
| | Dawn F McD | McDould | | Cremat | ion So ederic | ciet | y of | Mary | land, | Inc | 28 |
| | 23. PART I. Enter the diseases, or ahock, or heart fallure. | complications that caused List only one cause on as | tha daath. Do not ich iina. | antar tha mo | da of dying, aud | ch aa cardi | ac or respli | ratory arres | | pproxima | |
| | IMMEDIATE CAUSE (Final disease or condition reaulting in death) | Small (| CONSEQUENCE OF: | mgo | buch | non | ner | - | 0 | on fat and | Death 70 |
| 2 | | b. | CONSEQUENCE OF): | | | | | | | | |
| 2 | Sequantially list conditions, If any, leading to immediata cause. Enter UNDERLYING | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | | |
| EHIIFICATION | CAUSE (Disease or injury that initiated eventa resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | | |
| AL C | PART II. Other algnificant condition | 18 confibuting to death bi | ut not resulting in | the undarlying | causa givan in | Part i. | 24a. WAS AN | | 24b. WERE- | | |
| פטוכ | _ +17/1al | Filorilla | Lust | | | _ | PERFOR | | OF DEA | BLE PRIOR T ETION OF CA TH? ES 2 N | AUSE |
| IN: M | DID TOBACCO USE CONT | RIBUTE TO CAUSE O | F DEATH YES | | UNCERTAI | N 🗆 | | | | 20 20 | Ĭ |
| SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES NO | HOSPITAL: | | THER: | | | | | | | |
| É | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME C | Nursing Home | JRY AT | T | (Specify) | JURY OCCUP | RED | | _ |
| 6 | Natural 5 Pending Investigation | | | M 1 7 | ES 2 NO | | | | | | |
| EIED | 3 Suicide 8 Could not be detarmined | 28e. PLACE OF INJURY building, atc. (Speci | — At nome, ferm, atre | et, lactory, office | | 281. LOCAT | TION (Street e. r Town, State) | nd Number or | Rural Route Nu | mber, | |
| /MFL | | ICIAN: To the best of my knowle | | | | | | | euse(s) and m | enner ee et | |
| 5 | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | | 29c. LICENSE NUI | | . , | | IGNED (Month, | | - |
| | THUSIG | 1000 | | | D36 | 261 | 4 | ▶ 09 | /07/9 | 4 | |
| | 30. NAME AND ADDRESS OF PERSON WERE | / | oth (Item 27) (Type, Pri 05 Osler | | Towso | n. M | D 212 | 204 | | | |
| | SEP UP 1954 | To its designance stage | TURE | | | | | | | | |
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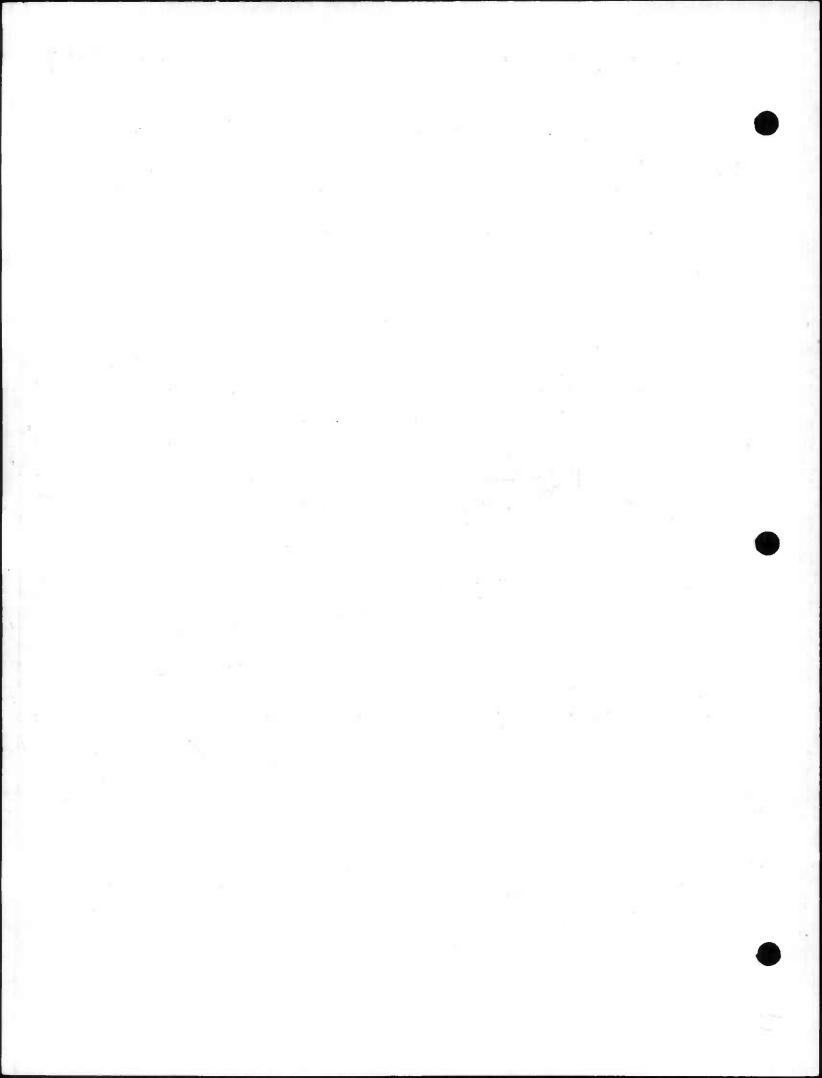
1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | | | | | | ICAIL | <u>UI</u> | DEA | 111 | | HEG. NO. | | | |
|--|--------------|--|-------------------------|---------------------------------------|--|---------------|--|----------------------|------------|----------------------|--------------------------------|--------------|-------------|---|
| | | 1. DECEDENT'S NAME (First, Middle, La James H. Phill | Jaille | s Hen | ry | Phi1 | 1i | ps | | 2. DATE O | 29-94 | W | YEAR | 3. TIME OF DEATH |
| | | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. Is | | | | | | | | | | 7:00 PM |
| | | 229-03-0735 | 1 M 2 F | | 30 YRS. | IF UNDER 1 | DAYS | IF UNDER | MIN. | 7. DATE O (Month, | Day, Year) | . 1 | Country | |
| 밁 | | | | |) y 143. | | | | | | -22-0 | | | rginia |
| 3 should | l ac | 98. FACILITY NAME (If not institution, gi | | | | 9b. CITY, | | OR LOCATION | | EATH | | 9c. COUN | ITY OF DE | ATH |
| 2, | CTOR | RESIDENCE OF DECEDENT | | | | | Bal | timo | re | | | | | |
| Pages 1, | 11.1 | 10e. STATE 10b. COU | | | 10c. CIT | Y, TOWN OF | R LOCAT | TION | | | | | | 10d. INSIDE CITY |
| 2 | DIR | Maryland | | | | | Ba 1 | timo | re | | | | | LIMITS? 1 YES 2 NO |
| permit. | AL A | 10e. STREET AND NUMBER | | | | | 101 | t. ZIP CODI | E | | | 10g. CITIZ | | HAT COUNTRY? |
| 15 | FUNERAL | 1032 Bristol P | lace | | | | | 2 | 1225 | | | | US | SA |
| 020 physician. burial-transit | 15 | 11. MARITAL STATUS | | NT EVER IN U.S. AI | | 13. W | AS DEC | CENDENT C | F HISPAN | IIC ORIGIN? | (Specify Yes | or No- | 14. RACE | — Americen Indian, White, atc. |
| ing phy | BY I | 1 Never Merried 2 Merried 3 Wildowed 4 Divorced | IF YES, GIVE | WAR OR DATES | 110 | | | 2 NO | | | cari, atc.) | | Specify | v. |
| ND 21215-0020 hospital or attending physician, ached for use as the burial-tran | ED E | 15. DECEDENT'S E | 1942 | | | ı | | | | _ | | | | White |
| or aff | 벁 | (Specify only highest gi | ade completed) | (0 | ECEDENT'S Give kind of D. Do NOT u | work done di | cupation with the current of the cur | ON ost of working | ng | 16b. | KIND OF BUS | SINESS/IND | JSTRY | |
| D pital | 1 2 | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | | Plun | n h e | r | | | | | | |
| AND he hospit detached | COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | | | 1 1 0 1 | n D C | | HED'S NAI | ME (First Mi | ddle, Maiden | Sumama) | | |
| 1 = - | E O | James Arth | ır Phil | lins | | | | | ary | | zabe | , | Mil | 1er |
| MARYL retained by the 5 should be | 2 0 | 19a, INFORMANT'S NAME (Type/Print) | | | b. MAILING | ADDRESS | (Street e | | | | r, City or Town | | | 101 |
| M e refa | | Mrs Dora Phi | llips | | | | | | | | lto, | | | |
| Tay by | 200 | 20a. METHOD OF DISPOSITION | | 20b. PLACE | AND DATE | OF DISPOSI | | | | DATE | <u> </u> | CATION — (| | vn, Stata |
| MOH age 6 ms director. | Ten I | 1 Surial 2 Cremation 3 R 4 X Donation 6 Other (Specify) | amoval from Stata | cemetery, cr | emetory or o | other place) | | | | } | | | | |
| Pag in | | 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE Rona | ald Wad | e, I |) i c22. N | IAME A | ND ADDRE | SS OF FAC | CILITY S t | ate. | Anat | omy | board |
| BALLIMORE, MARYL nours after death. Page 6 may be retained by ed in by the funeral director, page 5 should be or emoval. | CASHIII CA | 1 Antherty | 1/1/202 | - | | 6.5 | 5 5 W | .Bal | tim | oreS | t,Ba | lto, | MD2 | 1201 |
| n by the removal. | | 23. PART I. Enter the diseases, | or complications th | et caused the d | eath. Do i | not enter t | the mo | de of dv | ing, suct | h as cardi | ec or respi | ratory arre | est. | Approximate |
| hours ed in or re | | shock, or heart fellu | re. List only one ca | use on each lin | a. | | | • | | | | | | intarval Between Onset and Death |
| E 5 3 | | iMMEDIATE CAUSE (Final disease or condition | 150 | Esophage | al Ca | arcin | oma | | | | | | | 13 months |
| | | resulting in death) | a, | O (OR AS A CONSE | | | | | | | | | | 13 montens |
| executed and com to burial, | | | - b. | | | | | | | | | | | |
| 8 2 9 | ERTIFICATION | Sequantially list conditions, if any, lasding to immadiata | DUE TO | OR AS A CONSE | OUENCE O | F): | | | | | | - | | |
| | 2 | CAUSE (Disease or Injury | с | 1 | | | | | | | | | | |
| ertifical ling phy grene p | | that initiated events resulting in death) LAST | DUE TO | O (OR AS A CONSE | OUENCE O | F): | | | | | | | | |
| attend | CER 1 | | d | | | | | | | | | | | - |
| that the death ed by the atterth and Mental | | PART II. Other significant condit | ions contributing to | o deeth but not | resulting | in the unc | iariyin | g cause (| givan in | Part i. | 24s. WAS AN | | 246. | WERE AUTOPSY FINDINGS |
| that the ed by the the and | EDICAL | | | | | | | | | [| PERFOR | | | AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| Se Se se i | | | | | | | | | | | | X | - 1 | OF DEATH? 1 YES 2 NO |
| e law required bear of the Dept. of the | . Z | _DID TOBACCO USE | CONTRIBUT | E TO CAU | SE OF | DEAT | H Y | ES 🗆 | NO | | | | | |
| N: The law icate has State Dept | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | | | LACE OF D | EATH (Che | eck only one |) | | | |
| SICIAN: The Certificate the State | YSI | 1 TYES 2 X NO | | ☐ ER/Outpetlant | B DOA | 4 Number | | 10 5 Re | sidence | 6 🗆 Other | (Specify) | | | |
| ATTENDING PHYSICIAN: The law requestry and the state of the state been so after this certificate has been so after death with the State Dept. of the state of the | - T | 27. MANNER OF DEATH | 28a. DATE O (Month, | F INJURY Day, Year) | 28b. TIN | JURY | 28c. INJ WC | JURY AT | | 28d. DE\$C | RIBE HOW I | NJURY OCC | URED | |
| DING P | BY P | 1 X Natural 5 Pending 2 Accident Investigation | | | | М | | YES 2 | NO | | | | | |
| TTENDII TOR: A after de | 2 0 | 3 Suicide 8 Could not | pe building | OF INJURY — At h s, atc. (Specify) | oma, farm, | street, tacto | ry, offic | in . | | 28t. LOCA City or | TION (Street a Town, State) | ind Number | or Runal Ro | oute Number, |
| DR ATTEN DIRECTOR: hours after | : W | | | | | | | | | | | | | |
| AL DIRE | | ann! | YSICIAN: To the best of | | | | | | | | | | | |
| OSPIT JNERA thin 7 | COMPL | 2 MEDICAL EXAM | INER: On the beele of | examination and/or | Investigation | on, in my op | elnion, d | leath occur | red at the | time, date a | nd place, an | d due to the | CRUSO(E) | and menner as stated. |
| 는 HE HE HE HE | | 296 SIGNATURE OND TITLE OF CHRTS | NER | 110 | | | | 29c. LICI | ENSE NUN | ABER | 7 | 29d. DATE | SIGNED | Month, Day, Year) |
| TO THE HOSPITAL C TO THE FUNERAL D be filed within 72 ho | TO B | properso | well | My | | | | \mathcal{V}^2 | 141 | 47 | 4 | • | 8/ | 30/94 |
| | - | 30. NAME AND ADDRESS OF PERSON | | | | | | | | | | | | - |
| | | Dorothy Snow, A | | | St. | , Bal | tin | nore, | MD | 2120 | 1 | | | |
| | | SEP - 9 1994 | 32. REGISTR | AR'S SIGNATURE | | | | | | | | | | |
| | | 0 1001 | CAST CONTRACTOR | " Alertall | | | | | | | | | | |



FOR 1 - STATE BEGISTBAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

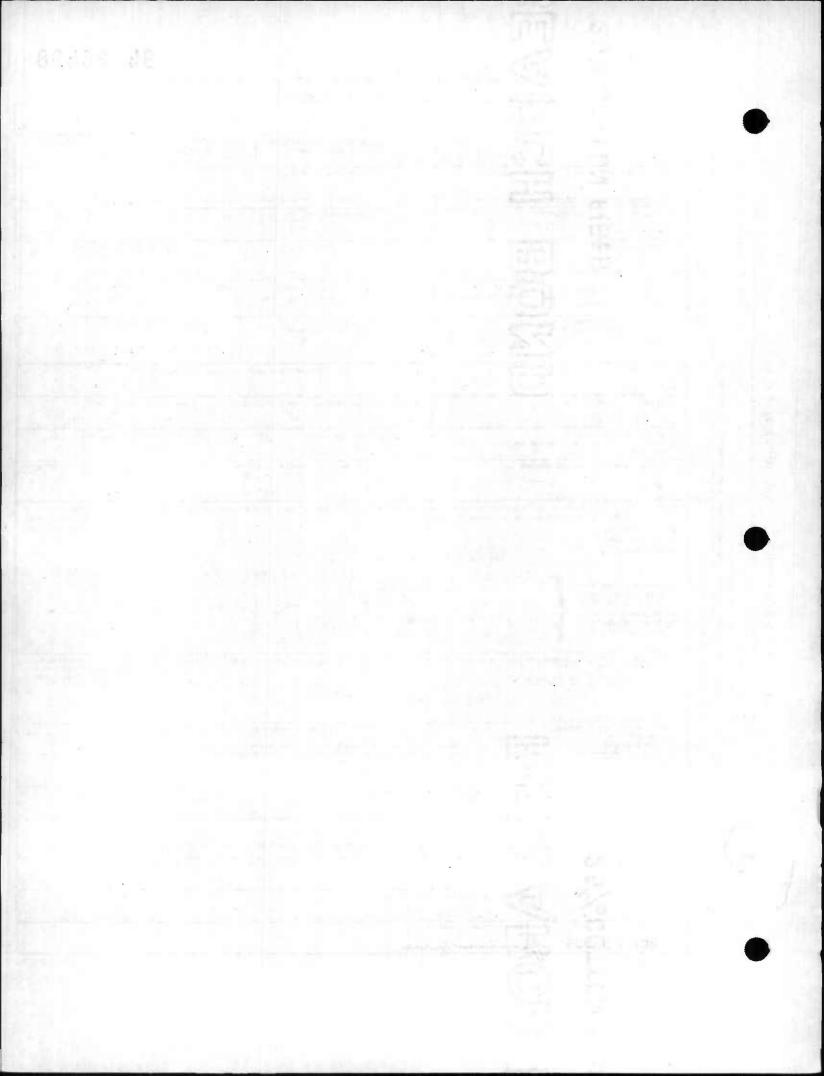
| | HEGISTHAN | | CENTIC | CALE | F DEATH | | REG. NO. | | |
|---------------|--|---|---|--|----------------------------|---------------------------|----------------------------------|-----------------------|--|
| į | 1. DECEDENT'S NAME (First, Middle, Last) 1. DO O DO 4. SOCIAL/SECURITY NUMBER | S, SEX B, AGE | Ker | | | 2. DATE OF | 20 | 90 | 3. TIME OF DEATH |
| | 214-64-2299 | 1 XM 2 - F | (In yrs. lest birthday) 39 YRS. | MONTHS DAY | | 7. DATE OF (Month, D) 2 2 | | Coun | HPLACE (State or Foreign try) Vland |
| œ | 90. FACILITY NAME (If not Institution, give str Liberty Medica | | | | altimore | | | COUNTY OF | DEATH |
| DIRECTOR | RESIDENCE OF DECEDENT | ir Center | | | | OTC | | | |
| RE(| 10a. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN OR LO | CATION | | | | 10d. INSIDE CITY |
| ۵ | Maryland | | | Balt | <u>imore C</u> | ity | | | 1 YES 2 NO |
| RAI | 10s. STREET AND NUMBER | | | | 101. ZIP CODE | _ | 10-9 | | WHAT COUNTRY? |
| FUNERAL | 2609 Keyworth | AVENUE 12. WAS DECEDENT EVER I | N U.S. ARMED | 13 WAS | 2121 DECENDENT OF HISPA | | Specify Van or N | US | |
| | 1 Never Married 2 Married | FORCES? 1 YES | 2 NO | If yes | specify Cuban, Maxic | en, Puerto Rica | in, atc.) | Blac | CE — American Indian, ck, White, atc. |
| ED BY | 3 Wildowed 4 Divorced | | | | V2124 | | | | Black |
| ETE | 15. DECEDENT'S EDUC (Specify only highest grade of | completed) | 18a. DECEOENT'S (Give kind of v life. Do NOT us | USUAL OCCUP vork done during e retired.) | ATION most of working | 16b. Ki | NO OF BUSINES | S/INDUSTRY | |
| 립 | Elementary/Secondary (0-12) | College (1-4 or 5 +) | | | e Artist | . | Se | 1f-em | ployed |
| COMPL | 17. FATNER'S NAME (First, Middle, Last) | | | czune | 18. MOTNER'S N. | | | | proyed |
| BE (| Nathaniel Park | er | | | Chris | tine | Baker | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | 1 | | net and Number or Rural | | - | | 0.1.5 |
| | Theresa Parker | / 100 | 2609 | | orth Ave | Ba Ba | | MD 21 ON — City or T | |
| | 20a, METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Ramo 4 Donation 5 Other (Specify) | val from State cen | netey, cremetory or of | ther place) | tery 9 | 12/9/ | Ro 1 | to M | own, Stata |
| | 21. SIGNATURE OF PUNERAL SERVICE LICE | ENSEE | 1 21011 | 22. NAM | E AND ADDRESS OF F | ACILITY | | LO , 11 | .D |
| | - Frank | 5 | V/. | | ity Fune | | | - 1 | WD 01001 |
| | 23. PART I. Enter the diseases, or co | omplications that cause | tha death. Do r | ot enter the | mode of dying, sur | ch as cardiac | or respirator | y arrest, | MD 21201 Approximate |
| | shock, or heart failure. L | ist only one cause on e | etch line. | | | | | | intarval Between Onset and Death |
| | disease or condition resulting in death) | | 'and | ome | hatta | | | | |
| | | DUE TO (OR AS | CONSEQUENCE OF | | 000 | | 4 | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | OUE TO (OR AS | CONSEQUENCE OF | MMU | no Clay | 100 | 1 | | |
| CA | cause. Enter UNDERLYING CAUSE (Disease or injury | | | 914 | alm | 2. | | | |
| TIE | that initiated events resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF | 7): | | | | | |
| E E | d | • | | | | | | | |
| AL | PART ii. Other significant conditions | contributing to death b | out not resulting I | n the underl | ying cause given in | Part i. 24 | a. WAS AN AUTO PERFORMED | | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| EDICAL | | | | | | 1 | TYES 2XX N | 10 | COMPLETION OF CAUSE OF DEATH? |
| Σ | DID TOPACCO LISE C | ONITRIBUTE TO | CALIFE OF | DEATH | VEC | | | | 1 TES 2 NO |
| AN | DID TOBACCO USE C | ONIKIBUTE TO | CAUSE OF | | YES NO | | | | |
| SIC | EXAMINER? 1)()() YES 2 NO | HOSPITAL: 1 Inpellent 2 ER/Outs | petient 3 NDOA | OTHER: | Nome 5 Rasidence | | pecify) | | |
| PHYSICIAN: | 27. MANNER OF OEATN | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIM | | INJURY AT WORK? | 1 | BE NOW INJUR | Y OCCURED | |
| BY | 1 (()(Natural 5 Pending 2 Accident Investigation | | | M 1 | YES 2 NO | | | | |
| ED | 3 Suicide 8 Could not be 4 Nomicide determined | 28s. PLACE OF INJURY building, atc. (Spec | — At home, term, s cify) | dreel, factory, o | ffica | 28f. LOCATIO | ON (Street and No own, State) | umber or Rural | Route Number, |
| COMPLET | 29a. CERTIFIER | 10N T- 0 1 1 1 1 | | | - 11500 002 | | | 0-00-00 | |
| MP | | IAN: To the best of my know t: On the basis of examination | | | | | | | (a) and manner as stated |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER |) | | | 29c. LICENSE NU | | | | |
| BE | | XVD- | | | Da | 0211 | 290 | S SIONE | D (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | ATN (ITEM 27) (Type, | Print) | 100 | - 0. 13 | 1, | 2 | - II '] |
| | F.SNA | MR, MD | 47 | 34 4 | win her | prily 9 | evens | , Ba | WINORIMA. |
| | SEP 0 9 1994 | 32. REGISTRAR'S SIGN | | | | | | | 7,11 |
| | 02.0000 | Topis Danden-Ka | | | | | | | |
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OHMN-16 Rev 1/89

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| | 1. DECEDENT'S NAME (First, | , Middle, Last) | | | | | DEATH | | REG. NO. | | | TIME OF DEATH |
|---------------------------------|--|--|--|---|--|--|--|--|--|---|--------------------|--|
| | ALBERT | AL | VIN | | P | AIILTS | | MC OC | ο ο ο ο ο ο ο ο ο ο ο ο ο ο ο ο ο ο ο | | EAR | 2.25.AM |
| | 4. SOCIAL SECURITY NUMB 215-10-3968 | BER | 5. SEX 1 1 1 F | 6. AGE (In y | rs. last birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7.04 | TE OF BIRTH Conth, Day, Year) 3-23-191 | | BIRTHPL | CE (State of Foreig |
| œ | 9a. FACILITY NAME (# not in | stitution, give | street and number) | | | 9b. CITY, TOWN | OR LOCATION OF D | | | 9c. COUNTY | OF DEAT | н |
| CTO | NORTH ARUN | CEDENT | | SOCT | ATION | GLEN | BURNIE | | | A | .A. (| COUNTY |
| DIRECTOR | MARYLAND | A N | NE ARUN | DEL | | LEN BU | | | | | | d. INSIDE CITY LIMITS? YES 2 XNO |
| ERAL | 100. STREET AND NUMBER 2002 NORM A | AN RO | DAD | | | 1 | 21060 | | | 10g. CITIZEI | U.S | · A · |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 X 3 Widowed 4 Divo | | 12. WAS OECEDENT FORCES? 1 [IF YES, GIVE WA | YES : | 2 3,40 | If yes, s | CENDENT OF NISPA pecify Cuben, Mexic S 2 NO Speci | an, Pue | IGIN? (Specify Yea rto Rican, atc.) | or No.— 14 | Bleck, W | American Indian, Inite, etc. WHITE |
| ETED | (Specify only | EDENT'S EDI | le completed) | | | USUAL OCCUPAT | | | 16b. KIND OF BUS | SINESS/INDUS | TRY | |
| COMPLE | Elementary/Secondary (0 | 0-12) | College (1-4 or 5 +) NON | | LINEMA | | | | GENERA | AL MC | TOR | S |
| E CO | 17. FATHER'S NAME (First, M. PHILLIP | fiddle, Last) | PA | LIUL | IS | | JULIA | | st, Middle, Maiden | Sumame) BITAU | JCIU | TE |
| TO B | 19a. INFORMANT'S NAME (7) | | MNINC | | | | and Number or Rural | | | | | . 21060 |
| | 20a. METHOD OF DISPOSITI | ION | | | ACE AND DATE (| OF DISPOSITION (| | 3/94 | | CATION — CIT | | |
| | 4 Donation 5 Other | (Specify) | | ° M°E | TADOWR | | EMORIAL | | | | | E, MD. |
| Ш | A TA | SERVICE | - Li | | | | COND A | | | | | RAL HO |
| | ahock, or he IMMEDIATE CAUSE (Fin | eart feilure | complications that List only one cause | caused the | ne death. Do n h Ilna. | GLEI | N BURNI | E, ch as c | MARYLA cerdiec or reapi | ND 2 | t, 106L | Interval Bet |
| TIFICATION | ahock, or h | clona, side arry | a. Carc Carc DUE TO (DUE TO (| LINE OR AS A CO OR AS A CO NIC | DINSEQUENCE OF THE PROPERTY OF | F): Of Street | pros | ta ad | MARYLA Perdiec or reapi fe ldev | ratory arrea | ι, | Interval Bets |
| MEDICAL CERTIFICATION | shock, or he shock | eleart feilure | a. Canc a. DUE TO (CANC DUE TO (Chivo (d. Augusta) One contributing to one contributing to one cause One contributing to one cause One contributing to one cause One | OR AS A CO | ONSEQUENCE OF | F): Of Sfree Svi 1 | pros Bl tive | ta cad Lu | erdiec or respi | Seas | 24b. WI AM | Interval Bett Onset and I |
| MEDICAL | Sequentially list condition resulting in seath) Sequentially list condition resulting in seath) Sequentially list condition resulting in seath) Sequentially list condition resulting in seath resulting in meeting in death) PART II. Other signification resulting in death) 25. WAS CASE REFERRED TO | clona, dilate ING any condition | a. Carc a. Carc Carc DUE TO (Chro d. Afri Chro d. Afri Chro Afri Afri Chro Afri Chro Afri Chro Afri Chro Afri Chro Afri Chro Afri Chro Afri Chro Afri Chro Afri Chro Afri Chro Afri Chro Afri Chro Afri Chro Afri Chro Afri Chro Afri Chro Afri Chro Afri Chro Afri Af | OR AS A CO | ONSEQUENCE OF THE PROPERTY OF | F): Of F): Of S free S rei' l In the underlyl CCe | Pros Bl hive (atiou | ch as co | erdiec or respi | Seas | 24b. WI AM | Interval Bets Onset and C Onset and C REAUTOPSY FIND ALLABLE PRIOR TO ADMPLETION OF CALL DEATH? |
| SICIAN: MEDICAL | Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) PART II. Other signification resulting in death) 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO | clona, dilate ING any condition | a. Carc DUE TO (DUE TO | OR AS A CO | DINSEQUENCE OF THE PROPERTY OF | P: Of P: S free () O O O O O O O O O | PLACE OF DEATH (C | factorial factor | erdiec or respi | AUTOPSY RMED? | 24b. WI | Interval Bets Onset and C Onset and C REAUTOPSY FIND ALLABLE PRIOR TO ADMPLETION OF CALL DEATH? |
| PHYSICIAN: MEDICAL | Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) Last cause. Enter UNDERLY CAUSE (Disease or injust that initiated events resulting in death) LAS PART II. Other signification resulting in death) 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 | clona, dilate ING ant condition we wanted to MEDICAL. | a. CAYC a. DUE TO (CAYC DU | OR AS A CC | ONSEQUENCE OF THE PROPERTY OF | Pi: Of Pi: S free () () () () () () () () () (| Pros Bl Aire (a + o v ng ceuse given in | factorial factor | erdiec or respi | AUTOPSY RMED? | 24b. WI | Approximate Interval Bett Onset and E Onse |
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| ETED BY PHYSICIAN: MEDICAL | Sequentially list condition resulting in seath) Sequentially list condition resulting in seath) Sequentially list condition resulting in seath) Sequentially list condition resulting in seath) Sequentially list condition resulting to immediate the cause. Enter UNDERLY! CAUSE (Disease or injut that initiated events resulting in death) LAS PART II. Other signification resulting in death) LAS PART II. Other signification resulting in death) LAS 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNIER OF DEATH 1 Netural 5 | idona, dilate ING ITY ING Investigation Could not be detarmined | a. DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (DUE TO (Morth, De 28a. PLACE OF building, of SICIAN: To the best of | OR AS A CO | ONSEQUENCE OF CONSEQU | in the underlyi CCE 28. OTHER: 4 Nursing No EOF 28c. | PLACE OF DEATH (Come 5 Realdence NORKY VES 2 NO lea | Luchas control of the | Leader or respirate to the control of the control o | AUTOPSY RMED? NJURY OCCUI | 24b. WI AM CC ON 1 | Interval Bety Onset and Conset an |
| COMPLETED BY PHYSICIAN: MEDICAL | ahock, or himmediate (Fir disease or condition resulting in seath) Sequentially list condition resulting in seath) Sequentially list condition resulting in seath) Sequentially list condition in sequence or injust that initiated events resulting in death) LAS PART II. Other signification in the sequence of the seq | iona, dilate ING ITY ST. T. Condition ING ITY ST. T. Condition ING ITY ST. T. Condition Investigation Could not be detarmined. | a. DUE TO (DUE | OR AS A CO | ONSEQUENCE OF CONSEQU | in the underlyi CCE 28. OTHER: 4 Nursing No EOF 28c. | PLACE OF DEATH (Come 5 Realdence UNRY AT ORKY VES 2 NO lea te and place, and du death occurred at th | Cod Cuu Check only 286. 1 | Leader or respirate to the control of the control o | AUTOPSY IMED? AUTOPSY IMED? IN NO NURY OCCUI | 24b. WI AM CC ON 1 | Interval Bets Onset and C Onse |
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| DIVISION OF VITAL RECORDS, I | The second of th |
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Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 0 0 filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE rman ours after death. Page 6 may be retained by the hospital or attending physician 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married If yes, specify Cubs BY 3 Widowed 4 Divorced BE COMPLETED 15. DECEDENT'S EOUCATION (Specify only highest grade complete 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work do Elementary/Secondary (0-12) College (1-4 or 5+) ssembl 17. FATHER'S NAME (First. notified at a 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 54 ustra 2 YNVIEW pe 20b. PLACE AND DATE OF DISPOSITION (Name of must remetory or other Nace) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY James U 701 medicai 23. PART I. Buter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feliure. List only one ceuse on each line. ŏ IMMEDIATE CAUSE (Final cremation, the disease or condition event, resulting in death) prior to burial, traumatic CERTIFICATION and Sequentially ilst conditions, if any, leading to immediate the attending physician Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL has been signed by the Dept. of Health and 23 shows any Dept. of 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 NO 26. PLACE OF DEATH (Check only one) this certificate HOSPITAL: OTHER 4 - Nursing Home 5 - Residence 8 - Other (Specify) 0 with the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? marked, 1 Natural 5 Pending Investigation BY 1 YES Accident DIRECTOR: After hours after death 3 Suicide 28a. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify) 28 is 6 Could not be determined COMPLETED TO THE FUNERAL DIRECT be filed within 72 hours at IMPORTANT: If Item 2 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER BE 를 품 물 223 2 30. NAME AND AODRESS OF PERSON 192. REGISTRAR'S SIGNATURE 9 1994

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

-9695

5. SEX

1 M 2 F

4. SOCIAL SECURITY NUMBER

94 26439

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

IF UNDER 24 HRS.

2

Specify:

2 NO

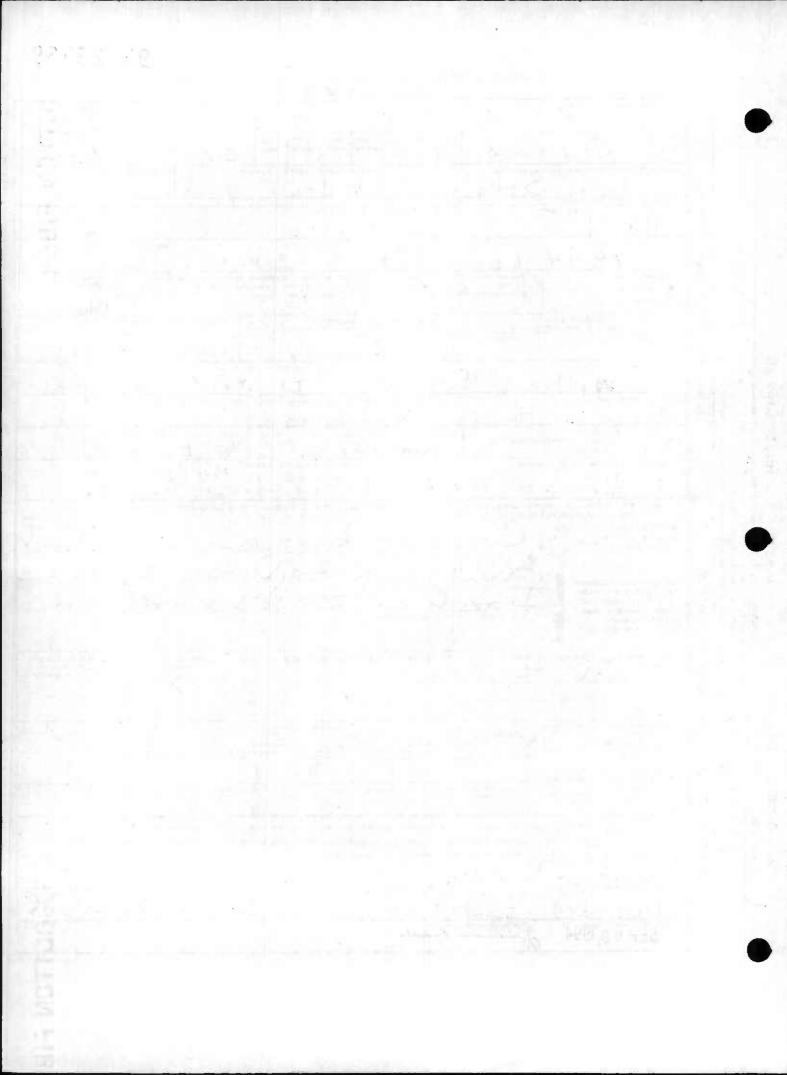
HOURS

DE12/2

6. AGE (In vrs. last birthday)

8

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO. 3. TIME OF OEATH 7. DATE OF BIRTH (Moint), Day, Year 6-19-8. BIRTHPLACE (State or Fores 9c. COUNTY OF DEATH 10d. INSIDE CITY 1 YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? 0 14. RACE — American Indian, Black, White, atc. Dac 16b, KIND OF BUSINESS/INDUSTRY octor 20c. LOCATION - City or To Ma -AURENS Approximete interval Betwe Onset and Dagth 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 U YES 2 NO 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 28f. LOCATION (Street and Number or Rural Route Number, City or Yourn, State) 29d, DATE SIGNED onth, Day, 9



3. TIME OF DEATH

10d. INSIDE CITY LIMITS? 1 YES 2 NO

8. BIRTHPLACE (State or Foreign Country)

1532 p

URECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should have the Cath with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

notified at 2

must be

or other traumatic event, the medical examiner

SMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

item 23 shows any injury,

0

is marked,

28

BE COMPLETED BY FUNERAL DIRECTOR

OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

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| | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH CERTIFICATE OF DEAT | | |
| i | 1. DECEDENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH | 3. TIME OF DEA |
| ١ | WILLIE PORTER | MONTH DA | AY YEAR |
| | | SEPTEMBLE 7 | 1994 1532 |
| l | 2 2 0 (50 ACA) | 24 HRS. 7. DATE OF BIRTH (Mogth, Day, Year) | 8. BIRTHPLACE (State or i |
| ı | 100 M 2 F 70 YRS. MONTHS WATS HOUNS | 3-5-19 | 124 Ga |
| I | 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION | ON OF DEATH | 9c. COUNTY OF DEATH |
| ļ | UNION MEMORIAL HOSPITAL BAITING | RE CITY | |
| ŀ | RESIDENCE OF DECEDENT | | 1 |
| Ì | 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CIT |
| Ì | Ma Balto | | t YES 2 |
| ı | 10s. STREET AND NUMBER / / 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? |
| | 1629 Abbotson St 21 | 218 | (1. S.A |
| ı | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF | F HISPANIC ORIGIN? (Specify Yes | or No. 14. RACE - American Inc |
| ľ | IF YES GIVE WAR OR DATES | n, Mexican, Puerto Rican, etc.) Specify: | Black, White, etc. |
| | 3 Wildowed 4 Divorced | эрөспу. | Specify: Bkd |
| I | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working) | 16b. KIND OF BUS | SINESS/INDUSTRY |
| | Elementary/Secondary (0-12) College (1-4 or 5+) Iffe. Do NOT use retired.) | 's | 6 4 |
| l | 12th | U. |). Army |
| I | 17. FATHER'S NAME (First, Middle, Last) 18. MOTH | HER'S NAME (First, Middle, Maiden | Surname) |
| I | Centroun | Kna | |
| l | 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number | or Bural Boute Number City or Tow | n. State Zin Code) |
| I | Shella Johnson 1/029 Aphotson | St Balto Md | 2/2/8 |
| | 200 METHOD OF DISPOSITION 206 PLACE AND DATE OF DISPOSITION (Name of | DATE 20C-LO | CATION - City or Town, State |
| | 1X Burlel 2 Cremetion 3 Removal from State cametery, crematory or other place) 4 Donation 5 Other (Specify) | + 9/12/94 ()c | Vinne Hills Md |
| | 21. SEGNATURE OF FUNERAL SERVICE LICENSEE .; 22. NAME AND ADDRES | SS OF FACILITY, | 17 |
| | March F | =, H - W901 | , 0 , , |
| | 10011 (1300) 4300 | Wabash A | Sue Basto nd 2 |
| | PART I. Enter the diseases, or complications that caused the death, DD npt enter the mode of dyl shock, pr heart failure. List pnly pne cause pn each line. | ing, auch as cardiac or respi | Iratory arreat, Approxim |
| I | IMMEDIATE CAUSE (Final | | Onset ar |
| | resulting in death) | | 8 D |
| H | DUE TO (OR AS A CONSEQUENCE OF): | | 0 0/ |
| | DIABETES | | 54 |
| | | | |

PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I.

CVA

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

20 YEARS 8 DAYLS

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO

24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

Intarval Batween

8 DAYS

5 YEARS

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 TYES 2 NO

| 26. PLACE OF DEATH (Check only one) | | | | | | | | | | |
|---|---------|----------------|--------------------------------|----------------------------------|--|--|--|--|--|--|
| HOSPITAL: 1 Inpatient 2 ER/Outpatient | 3 🗆 DOA | OTHE 4 - Nu | R: rsing Home 5 - Residence | 6 ☐ Other (Specify) | | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) 28b. TI | | IE OF JURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED | | | | | | |

4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(e) end manner as stated.

28s. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify)

2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

Surges MI) 30. NAME AND ADDRESS OF VERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Investigation

8 Could not be

DEPTEMBER 7,1994

AB 27 29

UNIVERSITY FAMILY PRACTICE 29 SONTH PACA STREET, BALTIMORE 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

SEP 0 9 1994

Sequentielly list conditions,

if any, leeding to immediate cause. Enter UNDERLYING

CAUSE (Disease Dr Injury

that initiated events resuiting in death) LAST

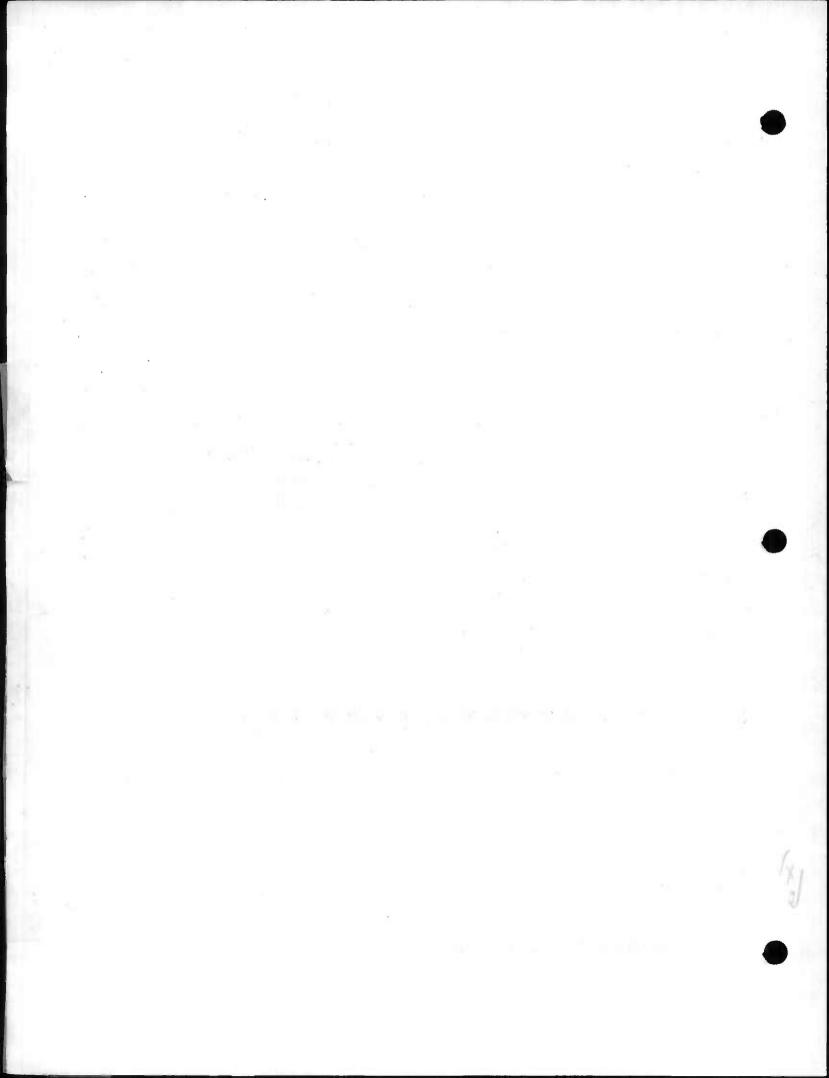
27. MANNER OF DEATH

1 Natural
2 Accident

3 Suicide

Sinis

DHMH-16 Rev 1/89



iours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 TO THE HUSS OLD TO THE WITH THE CORDS, P.O. BOX 68760, TO THE HUSS OLD ATTENDING PHYSICIAN: The law requires that the death certificate be executed with TO THE FUNET DIRECTAR After this certificate has been signed by the attending physician and completel to THE FUNET DIRECTAR After this State Dept. of Health and Mental Hygiene prior to burial, crem.

| | | FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | |
|--|---------------|--|---|---|--|-------------------------------|--|--------------------------------|---|--|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) MARTHA | W. | | PERR | Z. | 2. DATE OF DEATH SEPT. 0 | 7 199 4 | 3. TIME OF DEATH 12:03 PM | | |
| D | | 4. SOCIAL SECURITY NUMBER 219-36-2232 | | (In yrs. last birthday) 98 YRS, | MONTHS DAYS | | 7. DATE OF BIRTH (Month, Day, Year) 01-29-] | 8. BIFT Cour VI | THPLACE (State or Foreign ntry) RGINIA | | |
| z, 3 snouig | OR | 9a. FACILITY NAME (If not institution, give) 1300 E. LANVALE RESIDENCE OF DECEMENT | | | | OR LOCATION OF DE | CITY | 9c. COUNTY OF NON | | | |
| 7ages 1, 2, | DIRECTOR | 10a. STATE 10b. COUNT | NONE | 10c. CITY | Y, TOWN OR LOC | TIMORE (| TTV | | 10d. INSIDE CITY LIMITS? | | |
| Set permit. | | 100. STREET AND NUMBER 1300 E. LANVA | LE STREET | apt.5 | 1 | 101. ZIP CODE 21213 | | 109. CITIZEN OF | 1 12 YES 2 NO WHAT COUNTRY? D STATES | | |
| ne bunal-uan | BY FUNERAL | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D | N U.S. ARMED | 13. WAS D | | HC ORIGIN? (Specify Yearn, Puerto Rican, etc.) | a or No— 14, RAI Bla Spe | CE — American Indian, ick, White, etc. | | |
| n ce ec 101 | ETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | | 16a. DECEDENT'S (Give kind of w life. Do NOT us | USUAL OCCUPA: vork done during i e retired.) | TION most of working | 16b. KIND OF BU | AFRIC. | AN AMERICA | | |
| Once. | COMPL | 17. FATHER'S NAME (First, Middle, Last) | 2YEARS | NU | JRSE | 16. MOTHER'S NA | HOSP ME (First, Middle, Malden | Surrame) | | | |
| notified at | TO BE | ARTHUR W' | YNNE | 19b. MAILING | ADDRESS (Stree | | ARTHA JON | | | | |
| be | ĭ | FLORENCE WHITE 20a. METHOD OF DISPOSITION | 201 | 2309 | | | DATE 20c. LO |), MD. | 21216 | | |
| iner must | | 1 Burial 2 Cremation 3 XRem 4 Donation 5 Other (Specify) | cen | ALVARY | PEMETE 22. NAME | RY 9-12 AND ADDRESS OF FAC | 1-94 No | rfolk, | VIRGINIA | | |
| removal. | | 23. PART I. Enter the diseases, or | D. Seru | ad & | - 1 7 / 1 | 2 5 555 | CRUGGS F | DATITIO | MD 21213 | | |
| al, cremation, or remove | | shock, or heert failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. List only one cause on g | A CONSEQUENCE OF | nhi | | as cerdiec or respi | ^ | Approximate Interval Between Onset and Death | | |
| Hygiene prior to burial, or other traumatic e | CERTIFICATION | Sequentielly list conditione, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | • | A CONSEQUENCE OF | | | | | | | |
| and | MEDICAL C | PART II. Other significent condition | ns contributing to death b | out not resulting in | n the underlyi | ng ceuse given in | Part I. 24a. WAS AN PERFOR | RMED? | ib. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| 23 Per | AN: ME | DID TOBACCO USE CONT | 7 | OF DEATH YE | | | 10 | | 1 YES 2 NO | | |
| the State or item | PHYSICIAN: | EXAMINER? 1 X YES 2 NO 27. MANNER OF DEATH | HOSPITAL: 1 Inpatient 2 ER/Outs | petient 3 DOA | OTHER: 4 Nursing Ho | ome 5X Residence | | | | | |
| marked, | BY PF | Natural 5 Pending Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME | M 1 | NJURY AT YORK? YES 2 NO | 26d. DESCRIBE HOW I | | | | |
| | ETED | 3 Suicide 6 Could not be 4 Homicide determined | 28a. PLACE OF INJURY building, atc. (Spec | — At home, farm, st | treet, factory, off | lce | 26t. LOCATION (Street of City or Town, State) | and Number or Rural | Route Number, | | |
| other 72 hours ANT: If Item | COMPLET | 2 MEDICAL EXAMINE | ICIAN: To the best of my know ER: On the basis of exemination | | | | | | (a) and manner as stated. | | |
| be thed within IMPORTANT | TO BE | 296. GGANUHE AND TITLE OF CERTIFIE | tole | M | | 29c. LICENSE NUM | | | . 08,1994 | | |
| | | TARON LOCK | E, MD | 111 Peni | | | timore, N | | | | |
| | | 31. DATE FILED (Month, Day, Year) SEP 0 9 1994 | 32. REGISTRAR'S SIGN | ATURE | | | | | | | |

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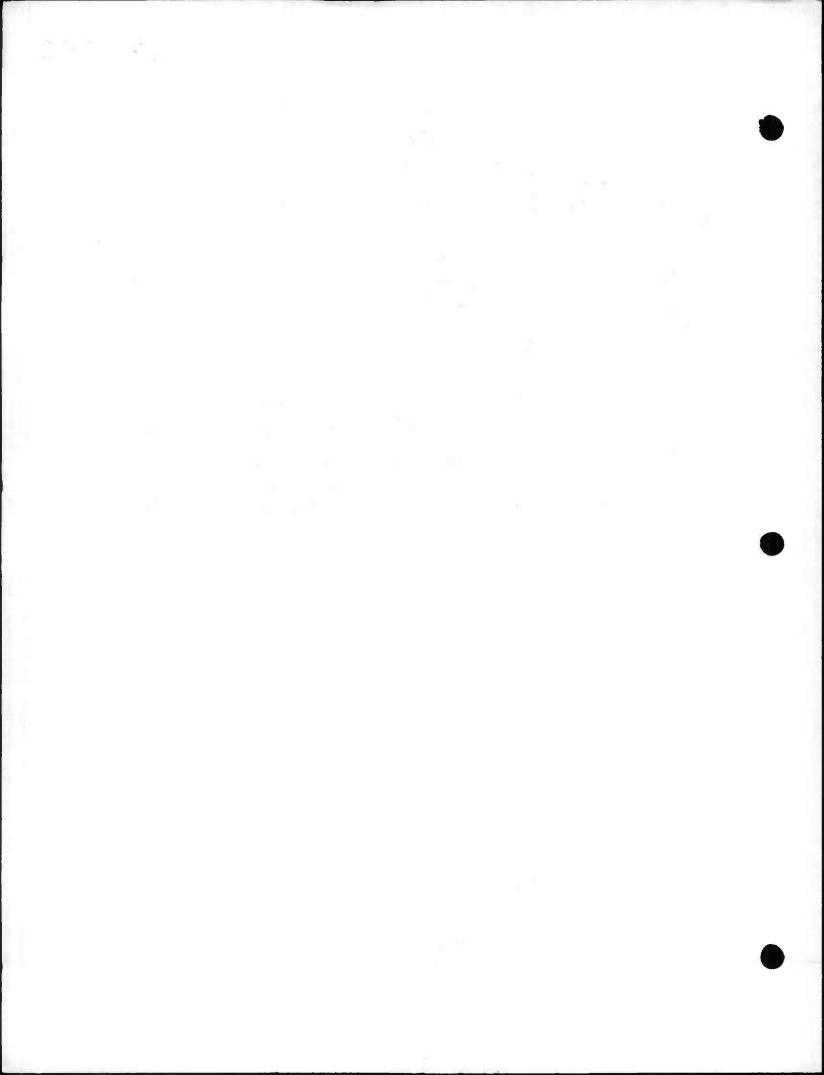
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31. DATE FILED (MONT)

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 CERTIFICATE OF DEATH REG. NO DECEDENT'S NAME (First, Middle, 2. DATE OF DEATH 3. TIME OF DEATH IF UNDER 1 YEAR 7. OATE OF B IF UNDER 24 HRS. RTHPLACE (State or Foreign Pages 1, 2, 3 should TOWN OR LOCATION OF COUNTY OF DEATH DIRECTOR CEDEN 10b. COUNTY 10d. INSIDE CITY 10c. CITY, TOWN OR LOCATION YES 2 NO een signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, of Health and Mental Hygiene prior to burial, cremation, or removal. FUNERAL ours after death. Page 6 may be retained by the hospital or attending physician. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 ANO 11. MARITAL STATUS 12/ 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-2 Merr If yes, specify Cuban, Mexican, Puerto Rican, 1 YES 2 NO Specify: IF YES, GIVE WAR OR DATES ВУ 4 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NQT_use retired.) 15. DECEDENT'S EDUCATION secily only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY ege (1-4 or 5+) once 75 BE notified 5 must be 20b. PLACE AND DATE OF DISPOSITION (Na METHOD OF DISPOSITION ner (Specify) Donation 5 0 examiner ERAL SERVICE LICENSEE medical diseases, or complications that caused the deeth. Approximate heart failure. List only one cause on each ij interval Between IMMEDIATE CAUSE (Final Onset and Death 44 event, the disease or condition resulting in death) ndition mondia DUE TO (OR AS traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUE that initiated events resulting in death) LAST 6 shows any injury, PART II. Other significent conditions contributing to death but not recuiting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 YES 2 NO OF DEATH? 1 TES 2 NO has been s Dept. of H PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h Item **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA nce 6 - Other (Specify) 6 the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED with t is marked, 1 Natural 1 YES 2 NO BY After death 2 Acciden 26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 26f. LOCATION (Street and Number or Rural Route Number, City or Yourn, State) BE COMPLETED 6 Could not be DIRECTOR 4 🗌 Homicide 23 g 29a, CERTIFIER CERTIFYING PHYSICIAN: To occurred at the time, date end place, and due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On 296. SIGNATURE AND TITLE OF CERTIFIER 4 268 9 OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 6 wo

32. REGISTRAR'S SIGNATURE



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| DIVISION OF VILAL RECORDS, P.O. | Section of |
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Item# 1 Per F.H. Film# G-715 09/09/94 R.M.

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Esther ROLOFF September 5. 1994 4:32 pm. M 4. SOCIAL SECURITY NUMBER 5. SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign (Month, Day DAYS HOURS 213-10-3140 1 M 2 X F 84 YRS. Md. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b, CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH DIRECTOR Franklin Square Hospital Rossville Baltimore RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore Middle River Md. 1 YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1706 Wilson Point Road use as the burial-transit 21220 United States Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ◯ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Rican, atc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Merried Spoothy: White BY 3 (Wildowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grad Pop Elementary/Secondary (0-12) College (1-4 or 5 +) 12th Grade Cafeteria Manager Baltimare County Schools director, page 5 should be detached 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) ĕ George H. Mack Augusta W. Witte BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Dorothy R. Hickey 3 Lucan Court Timonium, Maryland 21093 e 20e. METHOD OF DISPOSITION
1 (2) Burlet 2 Cremetton 3 Removal from State 20b. PLACEAND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must Lawn Cemetery 9/9/94 Baltimore, Maryland= 22. NAME AND ADDRESS OF FACILITY
Duda-Ruck Funeral Home of Dundalk, Inc. examiner filled in by the funeral ours after death. 7922 Wise Avenue Dundalk, Maryland 21222 medical 23. PART I. Enter the disesses, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fallure. List only one cause on each line. **IMMEDIATE CAUSE (Final Onset and Death** the disease or condition and completely fi Terminal Cardiomyopathy resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 9 if any, leading to immediate cause. Enter UNDERLYING prior CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): the attending p that initiated events resulting in death) LAST 6 PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL and shows any signed b 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO PHYSICIAN: has be 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) the State HOSPITAL:
1 Inpatient 2 ER/Outpatient 3 DOA 1 WES 2 NO OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, this with 1 Natural 5 Pending 1 YES 2 NO BY After 1 Accident 26e. PLACE OF INJURY — At home, farm, atreet, fectory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be DIRECTOR: 4 Homicide 29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee attend. FUNERAL I 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(e) end menner es stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: I 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Ker D43960 915/94 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Nabil Kadi, MD. 9000 Franklin Square Drive, Baltimore, Maryland 21237

22. REGISTRAR PSIGNATURE

31. DATE FILED (Month, Day, Year)

ITEM: 23 PART I, 27, PER MEO FILM G-715 9/26/94 t.t. Item#1 Per F.H. Film# G-715 09/09/94 R.M. 94 26444

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REGISTRAR REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 2. DATE OF DEATH DAY YEAR -EDMOND EDWIN ROSS S. 94 SEPT 5:02 0.5 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Dev. Year BIRTNPLACE (State or Foreign Country) HOURS 1 X M 2 - F YRS. 45 217-03-6630 9-29-1948 MARYLAND nus after death. Page 6 may be retained by the hospital or attending physician. in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR 403 NORMANDY AVE BALTIMORE CITY RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE CITY TY YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 403 NORMANDY AVENUE 21229 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-BALTIMORE, MARYLAND 21215-0020 14. RACE — American Indian, Black, White, etc. Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Ri 1 YES 2 NO Specify: BY IF YES, GIVE WAR OR DATES Specify: Specify: 3 Widowed 4 Divorced BLACK 6 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig Щ Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12th GRADE UNEMPLOYED Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Surname) te RAPHAEL ROSS THELMA BROWN BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 THELMA ROSS 403 NORMANDY AVENUE, BALTIMORE, MD. 21229 å 20e. METHOD OF DISPOSITION
1 \(\mathbb{X} \) Burlel \(2 \) \(\mathbb{C} \) Cremetion \(3 \) \(\mathbb{R} \) Removal from State \(4 \) \(\mathbb{D} \) Other (Specify) \(\ldots \) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 9-9-94 ARBUTUS CEMETERY ARBUTUS MARYLAND medical examiner OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY H. BROWN JR. FUNERAL HOME, P BALTIMORE ST., BALTIMORE, JOSEPH H. 1913 W. MD.21223 and completely filled in by the bunal, cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or haart failure. List only one cause on each line. Interval Betw IMMEDIATE CAUSE (Final Onset and Death the disease or condition MYOCARDIAL FIBROSIS event, reaulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEQUENCE OF): to burial, traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate attending physician CAUSE Enter LINDERLYING CAUSE (Disease or Injury or other / the attending phy d Mental Hygiene p DUE TO (OR AS A CONSEQUENCE OF). that initiated evants resulting in death) LAST injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO has been signed by t Dept. of Health and 23 shows any COMPLETION OF CAUSE YES 2 NO OF DEATH? 1 TYES 2 T NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate h HOSPITAL OTHER: DR ATTENDING PHYSICIAN: Inpatient 2 ER/Outpatient 3 DOA YES 2 NO 4 - Nursing Nome - Residence 8 - Other (Specify) 0 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF this cu 28c. INJURY AT WORK? 28d, DESCRIBE NOW INJURY OCCURED marked, 1 Natural 5 Pending M 1 YES 2 NO ВУ After i 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, offica building, etc. (Specify) 3 Suicide 69 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: / 8 Could not be COMPLETED 4 Homicide 28 determined Hem 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) end menner es stated. THE HOSPITAL C THE FUNERAL D filed within 72 h = TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT: II 2 🕅 MEDICAL EXAMINER: On the beals of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(a) and manner as stated. 29b. SIGNATURE, AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 0 Cino O.C.M.E. SEPT 6,1994 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE DE DEATN (ITEM 27) (Type, Print) DHORE K u. Penn Street, Baltimore, Maryland 21201 111 32. REGISTRAR'S SIGNATURE

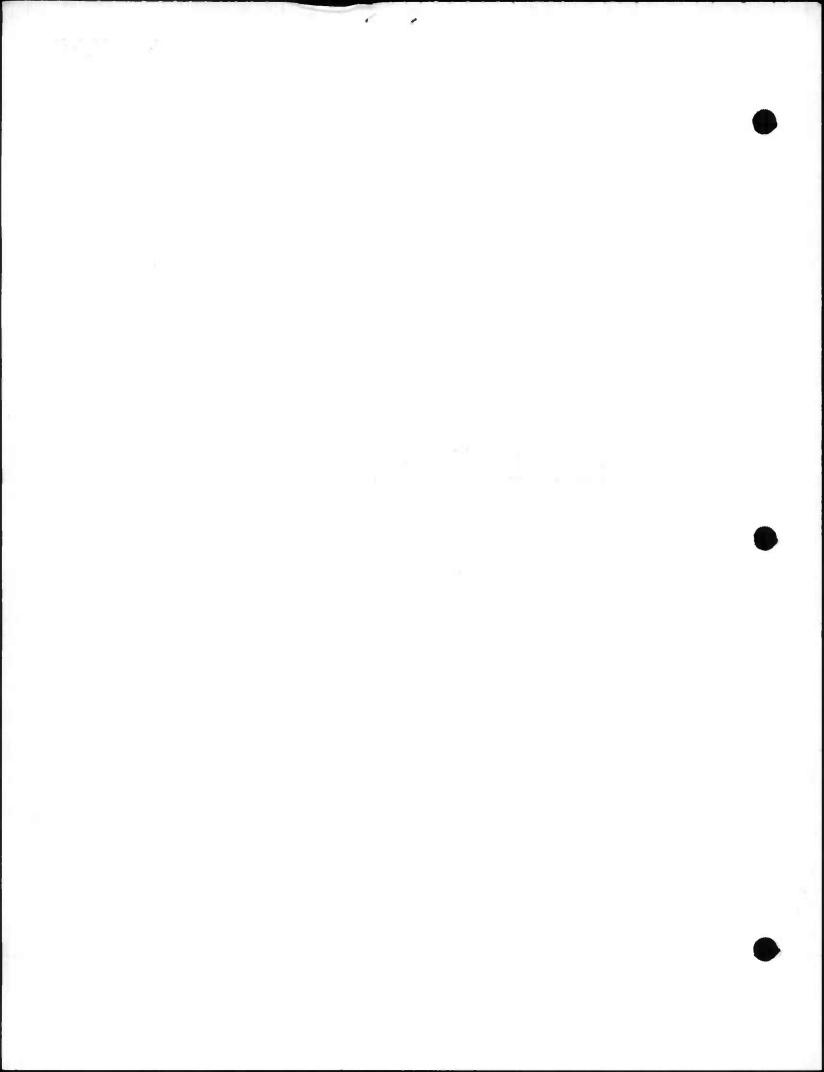
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| RATHABING PHYSICIAN: The law requires that the death certificate be executed within the control of the function of the retained by the intending physician and completely filled in by the functal director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 shows that the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
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| FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | MENTAL HYGIENE REG. NO. |
|-------------------------------------|---|----------------------------|
| CEOENT'S NAME (First, Middle, Last) | | 2. OATE OF DEATH |

| | 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | | |
|------------------|--|--|------------------------|--------------------------|---------------------|-------------------------------|----------------------------|------------|----------------------------------|--|--|--|
| | 1. DECEOENT'S NAME (First, Middle, Last) | | | | | 2. OATE OF DE | | | 3. TIME OF OEATH | | | |
| | William | William Ralph Regler | | | | | | | 10:20 P. M | | | |
| | 4. SOCIAL SECURITY NUMBER 5 | | in yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIR | , 1994 | 8. BIRTH | PLACE (State or Foreign | | | |
| | 213-03-8811 19. FACILITY NAME (If not institution, give stree | 1 ▼M 2 □ F | 76 YRS. | ,1917 | | | | | | | | |
| œ | The state of the s | 11-11-11-11-11-11-11-11-11-11-11-11-11- | i | | OR LOCATION OF O | EATH | | NTY OF D | | | | |
| DIRECTOR | St. Joseph's Hos | pital | | TOWS | ON | | B | ALTI | MORE | | | |
| Ö | 10e. STATE 10b. COUNTY | | 10c. CITY | TOWN OR LOCAT | ION | | | | 10d. INSIDE CITY | | | |
| 6 | MARYLAND BA | LTIMORE | | ILLE | | | | LIMITS? | | | | |
| AL | 10e. STREET AND NUMBER | | | 100 | 10g. CIT | 10g. CITIZEN OF WHAT COUNTRY? | | | | | | |
| FUNERAL | 12304 Нарру Н | ollow Rd. | | | 21030 | US | A | | | | | |
| 5 | | 2. WAS DECEDENT EVER IN | | 13. WAS DEC | ENDENT OF HISPA | NIC ORIGIN? (Spec | olfy Yee or No- | 14. RACE | - American Indian, | | | |
| | 1 Never Married 2 Merried | FORCES? 1 YES | | It yee, ap | 2 X NO Specif | | t, White, etc. | | | | | |
| ВУ | 3 XWidowed 4 Divorced | | | | | | | WH | ÎTE | | | |
| 삘 | 15. DECEDENT'S EDUCAT (Specify only highest grade col | rion mpleted) | 16a. DECEDENT'S I | SUAL OCCUPATION | ON st of working | 16b. KINO | OF BUSINESS/INC | DUSTRY | | | | |
| Ш | Elementery/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use | retired.) | • | | | | | | | |
| MP | 12 | | Cle | rical | | Pr | inting | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, I | Maiden Sumame) | | | | | |
| BE | William | James | Regler | | Grace | May | Sterne | r | | | | |
| 2 | 19e. INFORMANT'S NAME (Type/Print) | | | | nd Number or Rural | | | | | | | |
| - | Linda G. Hart | wig | 1 | 2302 Hap | py Hollo | ow Rd., | Cockeys | vill | e, MD 21030 | | | |
| | 20e. METHOO OF DISPOSITION 1X Buriel 2 ☐ Cremetion 3 ☐ Remove | 20b | PLACE AND DATEO | F DISPOSITION (Na | nie of | OATE 2 | 0c. LOCATION — | | | | | |
| | 4 Donetion 5 Other (Specify) | 1 2 M | Morela | nd Memor | ial Parl | K SPPT | Balto., | | | | | |
| | 21. SIGNATURE OF FUNDAL SURVICE LICEN | | met | 22. NAME AN | DADDRESS OF FA | CILITY | defold | Inc | | | | |
| | ▶ Bryanw | Clary | 27 | | J. Padon: | | | | | | | |
| | 23. PART I. Enter the diseases, or con | nplications that caused | the death Do no | | | | | | Approximate | | | |
| | anock, or heart failure. List only one cause on each line. | | | | | | | | | | | |
| - 1 | disease or condition resulting in death) a. CARDIAC REST | | | | | | | | | | | |
| | resulting in death) a | DUE TO (OR AS A | CONSEQUENCE OF | VVC2 I | | | | | | | | |
| _ 1 | AD (M DS CL. M DS CL. M DT A CONST | | | | | | | | | | | |
| <u></u> | Sequentially list conditions, our TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, our TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | |
| ᇤᅵ | CAUSE (Disease or Injury that initiated events | OUE TO (OR AS A | CONSEQUENCE OF | : | | | | | + | | | |
| | resulting in death) LAST | | | | | | | | | | | |
| | d | | | | | | | | | | | |
| A | PART II. Other algnificant conditions of | contributing to death b | ut not reaulting in | the underlying | cause given in | | AS AN AUTOPSY ERFORMED? | 24b. | WERE AUTOPSY FINDINGS | | | |
| 음 | | | | | | | YES 2 NO | | COMPLETION OF CAUSE OF DEATH? | | | |
| ME | | | | | | | | | 1 _ YES 2 _ NO | | | |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRIE | BUTE TO CAUSE O | F DEATH YES | □ NO □ | UNCERTAIL | N 🗆 | | | | | | |
| 등 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | OCOLTAL | 26. PLACE OF DEATH | | | | | | | | | |
| Š | 1 - YES 2 NO 1 | □ Inpatient 2 ER/Outp | | OTHER: 4 Nursing Hom | 5 Residence | 6 Other (Specif | fy) | | | | | |
| ξl | 27. MANNER OF DEATH | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME | | JRY AT RK? | 28d. OESCRIBE | HOW INJURY OC | CURED | | | | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | , | | 44 | ES 2 NO | | | | | | | |
| | 3 Suicide 8 Could not be | 28e. PLACE OF INJURY building, etc. (Spec | — Al home, ferm, at | reet, fectory, office | | | Street and Number | or Aural A | loute Number, | | | |
| E | 4 Homicide determined | ounanty, stat (opou | ,, | | | City or Town, | , 316/8) | | | | | |
| 1 | 290. CERTIFIER 1 CERTIFYING PHYSICIA | N: To the best of my knowl | edge, death occurred | at the time date | and place, and due | In the cause/e) as | ad manage on stat | ad | | | | |
| COMPLETED | | On the beele of examination | | | | | | | and manner as stated | | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | | | | | | |
| BE | 250. DATE SIGNED (MORRIT) | | | | | | | | (Month, Day, Year) | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO C | COMPLETED CAUSE OF DE | TH (ITEM 27) (Taxon) | Print) | N | 24) | 1 9 | - 6 | [- | | | |
| | Steven Mason, | | | | Ve. Suit | te 303 | Towers | MD | 21204 | | | |
| | | 22 REGISTRANGE OF A | | TIC DI | .vc, bull | , | TOWSUII, | תוז | 71704 | | | |
| | 31. DATE FILEO (MONTH), Day, Year) | COLUMN TO THE TOTAL TOTA | | | | | | | 1 | | | |
| - 1 | | | | | | | | | | | | |



REG. NO.

BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

L RECORDS, P.O. BOX 68760,

| Ė, | ş | 3 |
|----------|-----------------------|--------------------------|
| DIVISION | HOSPITAL DR ATTENDING | FLINERAL DIRECTOR: After |
| | 웃 | Ξ |
| | O THE | 뿚 |
| | 0 | 2 |

Impures that the death certificate be executed with. Flours after death. Page 6 may be retained by the hospital or attending physician.

| | | 1. DECEDENT'S NAME (First, I | Middle, Last) | | | | | | | | | 2. DATE O | | AV | | 3. TIME OF DEATH | |
|---|-------------|--|------------------------------|------------------------------|--------------|-------------|---|-----------|----------------|------------|-------------|----------------|------------------|----------------|--------------|--|----|
| | | Helen Rachlin Sept 6, 1994 | | | | | | | | YEAR | 1:30 | P | | | | | |
| | | 4. SOCIAL SECURITY NUMBER | ER | 5. SEX | 6. AGE (I | n yrs. last | birthday) | | DER 1 YEAR | IF UNDER | | 7. DATE O | | | S. BIRTN | PLACE (State or Foreig | n |
| | | 218-01-5959 | | 1 🗌 M 2 🔀 F | 7. | 3 | YRS. | MONTHS | S DAYS | HOURS | MIN. | | 25, | 1920 | Countr | aryland | |
| | | 90. FACILITY NAME (If not inst | titution, give si | treet and number) | | | | 9b. CI | TY, TOWN | OR LOCATI | ON OF DE | | 20 / 2 | | ITY OF D | | _ |
| | DIRECTOR | 200 Cross Keys Road Unit 23 Baltimore | | | | | | | | | | | | | | | |
| | Ä. | 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | | | | | | | | | | | 10d. INSIDE CITY | _ | | | |
| | ā | Maryland | | | | | | Ba | ltimo | ore | | | | | | LIMITS? | , |
| | AL | 10e. STREET AND NUMBER | | | | | | | 101 | . ZIP COD | E | | | ZEN OF Y | HAT COUNTRY? | | |
| | FUNERAL | 200 Cross Keys Road Unit 23 21210 U.S.A | | | | | | | | | | .S.A. | | | | | |
| | 5 | 11. MARITAL STATUS | | 12. WAS DECEOEN FORCES? 1 | T EVER IN | U.S. ARN | ED | 1: | 3. WAS DEC | ENDENT C | F NISPAN | IC ORIGIN? | (Specify Yes | or No— | 14. RACE | - American Indian, | _ |
| | ВУ Р | 1 Never Merried 2 h | | IF YES, GIVE V | MAR OR DA | TES X | 2 X NO If yes, specify Cuben, Mexicen, Puerto | | | | | | an, elc.) | | Speci | c, White, atc. | |
| | | | | | | | | | | | | | | | | White | |
| | TED | 15. DECE (Specify only | DENT'S EDUC highest grade | CATION completed) | | (Giv | e kind of w | ronk don | OCCUPATION MO | | g | 16b. F | IND OF BU | SINESS/IND | USTRY | | |
| | COMPLET | Elementery/Secondary (0-1 | 12) | College (1-4 or 5 | ·) | IIIe. I | Do NOT use | | | | | | | | | | |
| 8 | × | 12 17. FATHER'S NAME (First, Mid | 100 100 | | | | H | ous | ewife | | | | | At Hor | ne | | |
| 5 | | | Idle, Last) | | | - | | | | 18. MOTI | _ | AE (First, Mic | ldle, Maiden | Sumame) | _ | | |
| 9 | B | Henry | 400 t - 1 | | | | vin | | | | Ev | | | | | eenberg | |
| be notified at once | 2 | 190. INFORMANT'S NAME (Typ. | | | | | | | | | | | | rn, State, Zip | | | |
| 90 | | Mrs. Leslie | | ose | | | | | | | t La | ne, E | - | nore, | - | | |
| nst | | 20e. METNOO OF DISPOSITIO | 3 Remo | oval Irom State | certie | FBRE | APPY or AP | ARK | esition (Na | ares | sive | DATE | | CATION — | | | |
| E | | 4 Donation 5 Other (S | , ,, | | العلا | ck B | enef | it_ | & Rel | <u>ief</u> | Asso | d 9/8 | 194 | Randa | alls | town, MD | |
| 퉅 | | 21. SIGNATURE OF FUNERAL SERVICE LIQUENSEE 22. NAME AND ADDRESS OF FACILITY Sol Levinson & Bros. | | | | | | | | | | | | | | | |
| , S | | 6010 Reisterstown Rd, Baltimore, MD 21215 | | | | | | | | | | | | | | | |
| or removal. medical examiner must | | 23 PART . Enter the dis | esses, or c | omplicatione the | t caused | the dea | th. Do n | | | | | | | | | Approximate | _ |
| | | shock, or heaft fellure. List only one cause on each line. Interval Between Onset and Death Onset and Death | | | | | | | | | | | | | | | |
| the | | disesse or condition | • | COL | NO | AN | CFR | | | | | | | | | | |
| event, | | resulting in death) DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | |
| to bunal, cremation, imatic event, the | z | | | | | | | | | | | | | | | ļ | |
| giene phor to buna other traumatic | RTIFICATION | Sequentielly list conditione, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | |
| r trau | S | Cause Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | | | | | | | | |
| othe | E I | that initiated events | | DUE TO | (OR AS A | CONSECU | JENCE OF |): | | | | | | | | | |
| 9 H | CER | resulting in deeth) LAST | | | | | | | | | | | | | | | |
| of Health and Mental Hygiene hows any injury, or other | | PART II. Other algoriticent conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 24s. WAS AN AUTOPSY PINDINGS | | | | | | | | | | | | | | | |
| and y | DICAL | | | | | | | | underrying | 3 00000 8 | jiyon iii i | 0111 | PERFOR | | 240. | AVAILABLE PRIOR TO COMPLETION OF CAUS | |
| ealth Se ag | ED | | | | | | | | | | | — ¹ | YES 2 | NO | | OF DEATH? | - |
| #hows | Σ | DID TODA CCO LIC | E COLUTE | VID. 175 TO 64 | | | | | | | | | | | | 1 YES 2 NO | |
| 23 25 | CIAN | DID TOBACCO US 25. WAS CASE REFERRED TO | | GIBUTE TO CA | | | - | | | L UNC | ERTAIN | | | | | | |
| A E | [] | EXAMINER? | MEDICAL | HOSPITAL: | | | S. PLACE OF DEATN (Check only one) OTHER: | | | | | | | | | | |
| 8 8 | IYSI | 1 YES 2 NO | | 1 Inpatient 2 | | | | | ursing Home | | eldence (| | | | | | |
| marked, | РНҮ | 1 Netural 5 P | ending | (Month, D | | 1 | 28b. TIME INJU | JRY | | RK? | | 28d. DESCI | NOW I | NJURY OCC | URED | | |
| S m | B | | rvestigation | 28e. PLACE O | E IN ILIDY | 41.5 | e form 1 | | | 'ES 2 [| NO | | | | | | |
| after d | B | | ould not be etermined | building, | etc. (Specif | fy) | e, rerm, at | (reet, sa | ictory, office | | | City or | Town, Stete) | and Number | or Runal R | oute Number, | |
| Item 2 | PLET | 29e. CERTIFIER | | | | | _ | - | | | | | | | | | |
| 72 PG | F | (Check only | | CIAN: To the best of | | | | | | | | | | | | | |
| | COM | 2 MEDIC | AL EXAMINER | R: On the basis of e | camination | end/or Im | vestigation | ı, in my | opinion, de | eath occur | ed at the t | lme, date er | nd place, en | d due to the | cause(s | end manner es state | d. |
| MPORTANT: | ш | 296. SIGNATURE AND TITLE O | OF CERTIFIER | | | | | | | 29c. LICE | NSE NUM | BER | | 29d. DATE | SIGNED | (Month, Day, Year) | |
| IMP I | TO B | 6 L. C | | | | | | | | 12 | 773 | ? 0 | | | 9/7 | 194 | |
| | F | 30. NAME AND AODRESS OF | | COMPLETED CAUS | SE OF DEAT | TN (ITEM | 27) (Туре, і | Print) | | 1 - | | | | | 1 | 1. | |
| | | GAMY CON | EN, M | 0. 65 | 691 | V. C | MAS | .) | 1 | BA | N. 1 | 40 | 21 | 209 | | | |
| | | 31. DATE FILEO (Month, Day, Ye | ear) | 32. REGISTRA | R'S SIGNA | TURE | | | | | | | | | | - | |
| | N. | SEP 0 9 19: | 94 , | Lin Danie | em-Ra | التهايب | L | | | | | | | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a considered with a factor of the forest of the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should flours after death with the State Dept. of Health and Mental Hodiene prior to burial or remaint in a remaint in the state death with the State Dept. of Health and Mental Hodiene prior to burial mental in the management of the state of the BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLAND | | | F HEALTH AND | MENTAL HYGIEI | _ | | |
|--|--|--|---------------------------------|--|---|--|-----------------|--|--|
| | 1. OECEOENT'S NAME (First, Middle, Lest) ROBERT | G. | | OBY | JI DEATH | 2. DATE OF DEATH MONTH SEPT 0 | | 3. TIME OF DEATH 12:30 PM | |
| | 175-20-2817 | SEX 6. AGE (In yrs. It | YRS. | | YS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) DEC. 21,19 | | BIRTHPLACE (State or Foreign Country) RTAGE, PENNA | |
| TOR | 9e. FACILITY NAME (If not institution, give street UNION MEMORIAL H RESIDENCE OF DECEDENT | | | | WN OR LOCATION OF O | EATH | 9c. COUNTY | OF DEATH | |
| DIRECTOR | MARYLAND 10b. COUNTY | | 10c. CIT | r, TOWN OR L | DISCRIPTION BALTIMORE | | | 10d. INSIDE CITY LIMITS? Y YES 2 NO | |
| FUNERAL | 100. STREET AND NUMBER 512 S. COLLINS AVEN | | | | 10f. ZIP CODE 21229 | | | U.S.A. | |
| B | 11. MARITAL STATUS 1 Never Merried 2 K Merried 3 Wildowed 4 Divorced | P. WAS DECEDENT EVER IN U.S. A FORCES? 1 X YES 2 FIF YES, GIVE WAR OR DATES WW II | | If ye | DECENDENT OF HISPA e, specify Cuben, Mexico YES 2 NO Specific | | es or No 14 | Bleck, White, etc. Specify: WHITE | |
| COMPLETED | 15. DECEDENT'S EDUCATI (Specify only highest grade con Elementary/Secondary (0-12) | npleted) ((iii) | Give kind of v le. Do NOT us | USUAL OCCU vork done durin e retired.) | g most of working | 18b. KIND OF BI | DEALER | | |
| 10 m | 17. FATHER'S NAME (First, Middle, Last) GILBERT ROBY | | <u> </u> | JOINIT | | AME (First, Middle, Meide (UNKNOW) | n Surneme) | | |
| be notified TO BE | 199. INFORMANT'S NAME (Type/Print) DEBRA HANGEN | | | | | Route Number, City or To GRAND BA | | | |
| must b | 20e. METHOO OF DISPOSITION 1 X Burlel 2 Cremetion 3 Removal 4 Donation 5 Other (Specify) | proisposition the place) OREST | N(Name of VETS CEM. | 1 | NGS MII | or Town, State | | | |
| examine | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE | | | | | | | | |
| ent, the medical | IMMEDIATE CAUSE (Fine) | plicatione thet ceuead the determined to only one ceuse on each line. Arterioscler OUE TO (OR AS A CONSI | otic | card | mode of dying, suc | ch as cardiec or resp | piratory arrest | t, Approximate Interval Between Onset and Death | |
| y, or other traumatic event, the medical examiner must | Sequentielly list conditione, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initieted events resulting in deeth) LAST | OUE TO (OR AS A CONSE | | | | | | | |
| shows any injury, MEDICAL CE | PART II. Other significent conditions of Chronic Obstructions EMPHYSEMA | | | | | Part i. 24a. WAS AI PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| 23 sho AN: M | DID TOBACCO USE CONTRIB | | | | | N D INQU | IRY | 1 YES 2 □ NO | |
| ed, or item 23 s PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 28. PLACE OF DEATH (Check only one) OTHER: 1 Nursing Home 5 Residence 8 Other (Specify) | | | | | | | | |
| marked, BY PH | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 5 Pending (Month, Day, Year) INJURY WORK? | | | | | | SCRIBE HOW INJURY OCCURED | |
| 28 is TED | 3 Suicide S Could not be 4 Homicide determined | 28e. PLACE OF INJURY — At h building, etc. (Specify) | ome, ferm, s | treet, factory, | office | 281. LOCATION (Street City or Town, State | | Rural Route Number, | |
| OMPLE | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. WEDICAL EXAMINER: On the base of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner ee state | | | | | | | euse(e) and manner se stated. | |
| THE PARTY | 29b. SIGNATURE AND TITLE OF CERTIFIER LONALD G. Winght MD | | | | O . C . M | | | | |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print)

Donald G. Wright M.D.

SEP 0 9 1994

111 Penn Street, Baltimore, Maryland 21201

DHMH-18 Rev 1/89



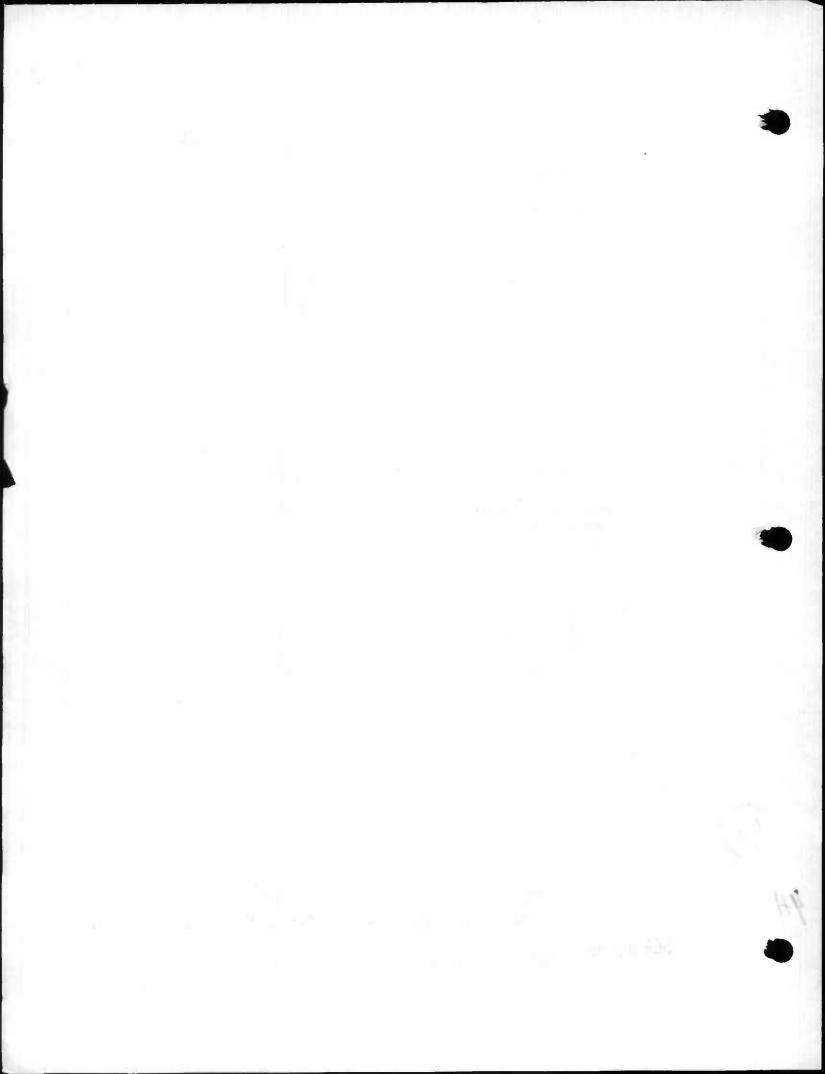
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| P.O. BOX 68760, | varutad |
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| OR | that |
| IVISION OF VITAL RECORDS, P.O. | The Tay Thomas PHYSICIAN. The law remires that the death certificate he exemped with |
| | ME |
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| OF | PHYSIC |
| ON | NDING |
| 115 | |
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| - | DO |
| 117 | 90. |

| | | 1. DECEDENT S NAME (FIRST, MIDDIE, LEST) | | |
|---|--------------------|---|------------------------------|---|
| | | Wendy Alicia Sco | W | endy Al |
| | | 4. SOCIAL SECURITY NUMBER 214-70-9644 | 5. SEX | 6. AGE (In yrs. I |
| pin | | 9a. FACILITY NAME (If not institution, give | | |
| permit. Pages 1, 2, 3 should | S S | STELLA | MARIS | HOSPI |
| 5, | DIRECTOR | RESIDENCE OF DECEDENT | | |
| ages | 끮 | 10a. STATE 10b. COUNT | | |
| Jif. F | 0 | MARYLAND | n/a | |
| t per | AA! | 10e. STREET AND NUMBER | DATE | DCON |
| physician. burial-transit | FUNERAL | 1948 N. | | |
| hysici urial- | 5 | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDEN | TEVER IN U.S. A |
| fing | В | 3 Wildowed 4XXDivorced | IF YES, GIVE | YES 2 |
| r attenduse as | COMPLETED | 15. DECEDENT'S EOU (Specify only highest grade | JCATION e completed) | 16a. 0 |
| for 1 | Ш | Elamentery/Secondary (0-12) | College (1-4 or 5 2 YEARS | +) |
| he hospit detached once. | ₩. | | 2 YEARS | PHI |
| by the hos | BE CO | JOSEPH | SEWELL | |
| iours after death. Page 6 may be retained by di in by the funeral director, page 5 should be or removal. medical examiner must be notified at | TO B | 190. INFORMANT'S NAME (Type/Print) WANDA E | . SCOT | Т 2 |
| age 6 may be director, page er must be | | 20s. METHOD OF DISPOSITION 1 Xi / Burlet 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | noval from State | 20b. PLAC |
| Page dire | | 21. SIGNATURE OF FUNERAL SERVICE LI | | |
| r death. Pag he funeral din al. | | * Karen - | m - 7 | Kog |
| d in by the for removal. | | 23. PART i. Enter the diseesea, or ahock, or heart fallura. | complications the | t caused the c |
| filled in tion, or the m | | IMMEDIATE CAUSE (Final | Λ . ? | > ^ |
| tely fratio | | disease or condition resulting in deeth) | e. A11 | 25 |
| omplete omplete il, crema | | | OUE TO | (OR AS A CONS |
| e be execute sician and conion to burial traumatic | N O | Sequentially list conditions, | b | |
| cian ior to | Ā | If any, leeding to immediate cause. Enter UNDERLYING | OUE TO | (OR AS A CONS |
| ertificate ing physi giene pr other t | 윤 | CAUSE (Disesse or injury | c | (OR AS A CONS |
| th certi | CERTIFICATION | that initiated eventa resulting in deeth) LAST | | (41111111111111111111111111111111111111 |
| atter atter | 핑 | | d | |
| the dea y the att od Menta injury, | AL | PART il. Other algnificent condition | na contributing to | death but not |
| that ned by ith an | 2 | | | |
| requires reen sign of Heat | ME | | | |
| NDING PHYSICIAN: The law requires that the death certificate be executed within a state this certificate has been signed by the attending physician and completely filled ar death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or is marked, or Item 23 shows any Injury, or other traumatic event, the m | PHYSICIAN: MEDICAL | DID TOBACCO USE | CONTRIBUT | E TO CAL |
| N: The i | CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | |
| SIAN: prtifica he Sta or it | YSI | 1 - YES NO | 1 Inpatient 2 | ER/Outpatient |
| HYSIC his ce with ti | H | 27. MANNER OF/DEATH 1 Natural 5 Pending | 28a. DATE OF (Month, E | INJURY Pay, Year) |
| NG PHYS fler this c eath with marked, | B | 2 Accident Investigation | | |
| NDIII | 0 | 3 Suicide 8 Could not be | 28a. PLACE C building. | OF INJURY At I etc. (Specify) |

| | 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | |
|-------------------------------|---|---|---|---|--|--|--|
| | 1. OECEOENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH | 3. TIME OF DEATH | | | |
| OR | Wendy Alicia Scott Wendy Alicia Sewel | 1 Scott | MONTH OB S | 4 9 30 A M | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 1 \square M 2/ \square F 0. AGE (In yrs. last birthday) IF UNDER 1.1 \square M 2/ \square F 37 YRS. MONTHS 0 | YEAR IF UNDER 24 HRS. DAYS HOURS MIN. | (Month, Day, Year) | BIRTHPLACE (State or Foreign Country) MARYLAND | | | |
| | 99. FACILITY NAME (If not institution, give street and number) STELLA MARIS HOSPICE | TOWSON | | Y OF DEATH | | | |
| 딦 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR | LOCATION | | | | | |
| COMPLETED BY FUNERAL DIRECTOR | MARYLAND n/a | BALTIMOR | | 10d. INSIDE CITY V LIMITS? 1 PES 2 NO | | | |
| | 1948 N. PATTERSON PARK | 21213 | UNITE | OF WHAT COUNTRY? | | | |
| | 1 Never Married 2 Married FORCES? 1 YES 2 INO | S DECENDENT OF HISPANI es, specify Cuben, Mexican YES 2 100 Specify | C ORIGIN? (Specify Yes or No — 10, Puerto Rican, atc.) | 6. RACE — American Indien, Black, White, atc. Specify: BLACK | | | |
| | 15. DECEDENT'S EOUCATION (Specify only highest grade completed) Elamentery/Secondary (0-12) - 2 YEARS 16a. DECEDENT'S USUAL OCCI (Give kind of work done duri life. Do NOT use refired.) PHLEBOTOMIS | ing most of working | 166. KINO OF BUSINESS/INDUS | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) JOSEPH SEWELL | | ME (First, Middle, Maiden Sumame) | | | | |
| TO BE | 198. INFORMANT'S NAME (Type/Print) WANDA E. SCOTT 4701 FLAT | Street and Number or Rural R | oute Number, City or Town, State, Zip C #47 E, UNION | OCITY 30219 | | | |
| | 20s. METHOD OF DISPOSITION 1 All Mouriet 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | ON (Name of ORIAL PAR | OATE 20c. LOCATION - CH | | | | |
| | | ME AND ADDRESS OF FAC | | | | | |
| | * Karen M. Koger WM | . C. MARC | H FH1101 E | . NORTH AVE. | | | |
| CERTIFICATION | 23. PART i. Enter the diseasea, or complications that caused the death. Do not enter the above, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in deeth) OUE TO (OR AS A CONSEQUENCE OF): b. OUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease or injury that initiated events | e mode of dying, such | aa cerdiec or reapiratory arres | Approximate interval Between Onset and Death | | | |
| | resulting in deeth) LAST d. | | | | | | |
| N: MEDICAL | PART II. Other algnificent conditions contributing to death but not resulting in the under DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH | | PERFORMEO? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO | | | |
| ᅙ | HOSPITAL: OTHER: | 26. PLACE OF DEATH (Che | ck only one) | | | | |
| PHYSICIAN: | AT MANUEL OF DESTRICT | g Homa 5 🗆 Realdenca (| 28d. DESCRIBE HOW INJURY OCCU | | | | |
| ВУ Р | 1 Natural 5 Pending (Month, Day, Year) INJURY 2 Accident Investigation | WORK? | 200. DESCRIBE NOW INSURT OCCU | REO | | | |
| <u>۵</u> | 3 Sulcide 8 Could not be datarmined 28a. PLACE OF INJURY — At home, term, street, factory building, etc. (Specify) | , office | 281. LOCATION (Street and Number or City or Town, State) | Rural Route Number, | | | |
| COMPLET | 29e. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and manner as stated. MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(a) end manner ee stated. | | | | | | |
| w I | 29b SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUM | BER 29d. DATE S | SIGNED (Month, Day, Year) | | | |
| TO B | Tremole & authorimo | U256 | 43 19 | 16/94 | | | |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kendall R. Faulkner, MD 2300 Dulaney Valley Road, Towson, Maryland 21204 | | | | | | |
| | 31. DATE FILED (MORITH, Day, Year) SEP - 9 1994 Julia Murther Redail | | | | | | |

| 2 | 2 | E | |
|--|--|---|---|
| DIVISION OF VITAL RECORDS, P.O. BOX 68/6 | HOSPITAL DHAMMONG PHYSICIAN: The law requires that the death certificate be executed | UNEFFER THE STATE After this certificate has been signed by the attending physician and com- vith The Conference attn with the State Dept. of Health and Mental Hygiene prior to burial, (| |
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| 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | |
|---|---|---|---|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) ROBERT | | ATE OF DEATHS - 3 0 - 0 / 3 TIME OF DEATH | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 1 MM 2 F | AGE (In yrs. lest birthdey) F UNDER 1 YEAR IF UNDER 1 YEAR HOUF | IDER 24 HRS. 7. DATE OF | Opy. Year) | BIRTHPLACE (State or Foreign Country) Maryland | | |
| - | 9s. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOC | 626 | 13/55 9c. COUNT | Y OF DEATH | | |
| DIRECTOR | RESIDENCE OF DECEDENT | W. tranklin Balton | none | Balti | more city | | |
| | Maryland Baltimore | 10c. CITY, TOWN OR LOCATION | re city | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | |
| RAL | 10s. STREET AND NUMBER | 10f. ZIP C | ODE | 1 * | N OF WHAT COUNTRY? | | |
| FUNERAL | 11. MARITAL STATUS 12. WAS DECEDENTARY | ER IN U.S. ARMED 13. WAS DECEMBEN | T OF HISPANIC ORIGIN? | | U.S.A. | | |
| B∡ | Never Merried 2 Merried FORCES? 1 A IF YES, GIVE WAR C | YES 2 NO If yes, specify C | uban, Mexicen, Puerto Ric | an, etc.) | I. RACE — American Indian, Black, Whita, atc. | | |
| ETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of wo life. Do NOT use retired.) | orking 16b. K | IND OF BUSINESS/INDUS | STRY | | |
| 교 | Elementary/Secondery (0-12) College (1-4 or 5 +) N/A | N/A | | N/A | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | OTHER'S NAME (First, Mid | | | | |
| BE BE | N/A 198. INFORMANT'S NAME (Type/Print) | | vella Ster | | | | |
| 5 | Roslyn Pack | 19b. MAILINO ADDRESS (Street and Num 2536 Loyola S | | | | | |
| nst pe | 20e METHOD OF DISPOSITION 1 G Burlei 2 Cremation 3 Removal trom State | 20b. PLACE AND DATE OF DISPOSITION (Name of | DATE | 20c. LOCATION — City | | | |
| E | 4 □ Donation 5 □ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | GARRISON FOREST VA C | | OWINGS MI | LLS, MD | | |
| i examiner must be notified at once. TO BE CON | 22. NAME AND ADDRESS OF FACILITY MARCH FUNERAL HOME EAST 1101 E. NORTH AVENUE/BALTIMORE, MD 21202 | | | | | | |
| , the medical | 23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Daath disease or condition | | | | | | |
| even | | AS A CONSEQUENCE OF): | The stage | - gracem | e mattie | | |
| r other traumatic event, RTIFICATION | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEDUENCE OF): | | | | | | |
| - 000 | CAUSE (Disease Dr injury that initiated avents resulting in death) LAST | | | | | | |
| 를 끊 | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS | | | | | | |
| S S | - Continuing to dear | in out not resulting in the underlying cause | | PERFORMED? YES 2 NO | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | 28 PLACE OF | DEATH (Check only one) | | | | |
| YSIC | EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpatient 2 ERG | QT/HER: | Residence 8 Other (S | pecify) | | | |
| marked, or item 23 shows BY PHYSICIAN: ME | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | RY 285 TIME OF 28c IN HIGH AT | 28d. DESCR | IBE HOW INJURY OCCUR | ED | | |
| | | URY — At home, tarm, street, factory, office Specify) | 281. LOCATION City or 3 | ON (Street and Number or I fown, State) | Rural Route Number, | | |
| y / ≥ | 29s. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, dats and place, and due to the cause(s) end manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dats and place, and due to the cause(s) end manner as stated. | | | | | | |
| TO BE CO | 29b. SIGNATURE AND PITTER CENTIFIER | | 32158 | 29d. DATE S | GNEP (Morith, Day, Year) | | |
| | John Parikh, MD 821 N Futaw St, Suite 407, Baltimore, MD 21201. | | | | | | |
| | 31. DATE FLED (Month, Day, Year) 32. REGISTRAR'S S | IGNATURE | 11 1 1 | | | | |



MARYLAND 21215-0020 BALTIMORE.

BOX 68760 P.0.

Page 6 may be retained by hours after death. executed within 24 death certificate be The law requires that the OR ATTENDING PHYSICIAN:

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31. DATE FILED (Month, Day, Year)

SEP 0 9 1994

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last. 2. DATE OF DEATH 3. TIME OF DEATH YEAR 8. BIRTHPLACE (State or Foreign Country) ELIZABETH MARY SHINER SEPTEMBER 5. SEX 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year 216-80-7535 1 M 2 X F 79 YRS. May 23, 1915 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR UNION MEMORIAL HOSPITAL BALTIMORE CITY 10c. CITY, TOWN OR LOCATION 10a STATE 10h COUNTY 10d. INSIDE CITY Maryland Baltimore 1 X YES 2 NO the funeral director, page 5 should be detached for use as the burial-transit permit. 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 4736 Elison Avenue 21206 United States the hospital or attending physician. 11 MADITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 W Merried BY Specify 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondery (0-12) College (1-4 pr 5 +) Homemaker once. 17. FATHER'S NAME (First, Middle, Last) 16, MOTHER'S NAME (First, Middle, Maiden Surname) 3 Joseph Smith Mary Connely BE notified a 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Shirley Billy 2107 Southern Avenue Baltimore, Md. 21206 pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must Gardens of Faith Cemetery 9/10/94 Baltimore, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Mark T. Zavoyna Marli Leonard J. Ruck, Inc. 5305 Harford Road Baltimore. 21214 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, filled in by Approximata ahock, or haart failura. List only one cause on each line. Intarval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition and completely fi o burial, cremation RENAL FAILURE 3 wecks resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF) METTASTATIC LUNG CARRINGMA-DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequantially list conditions, 2 the attending physician in Mental Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (DR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 0 PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL 24a. WAS AN AUTOPSY signed by the PERFORMED? shows any COMPLETION OF CAUSE 1 TES 2 NO 1 TYES 2 NO t. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO has be Dept. 1 PHYSICIAN: UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one Item certificate the State HQSPITAL: OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 YES 2 NO Inpatient 2 ER/Outpatient 3 DOA 0 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c marked, 1 Natural м 1 YES 2 NO BY After death Accident Investigation 28e. PLACE OF INJURY — At home, ferm, street, factory, offica building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcida 66 6 Could not be determined DIRECTOR: / COMPLETED 4 Homicide 28 Item 29a CERTIFIER 1 📝 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(e) end manner ee stated. HOSPITAL FUNERAL FWITIN 72 F 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(a) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month Day Year) BE AU41764 35 AU3790 September 7, 1994 MD 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

TOWN MO

TA S. PAC PACE ST

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32. REGISTRAR'S SIGNATURE

Develor Radall

DHMH-18 Rev 1/89

Control of the Party of the State of the Sta

PHYSICIAN: The law requires that the death certificate be executed within the found after death. Page 6 may be retained by the hospital or attending physician.

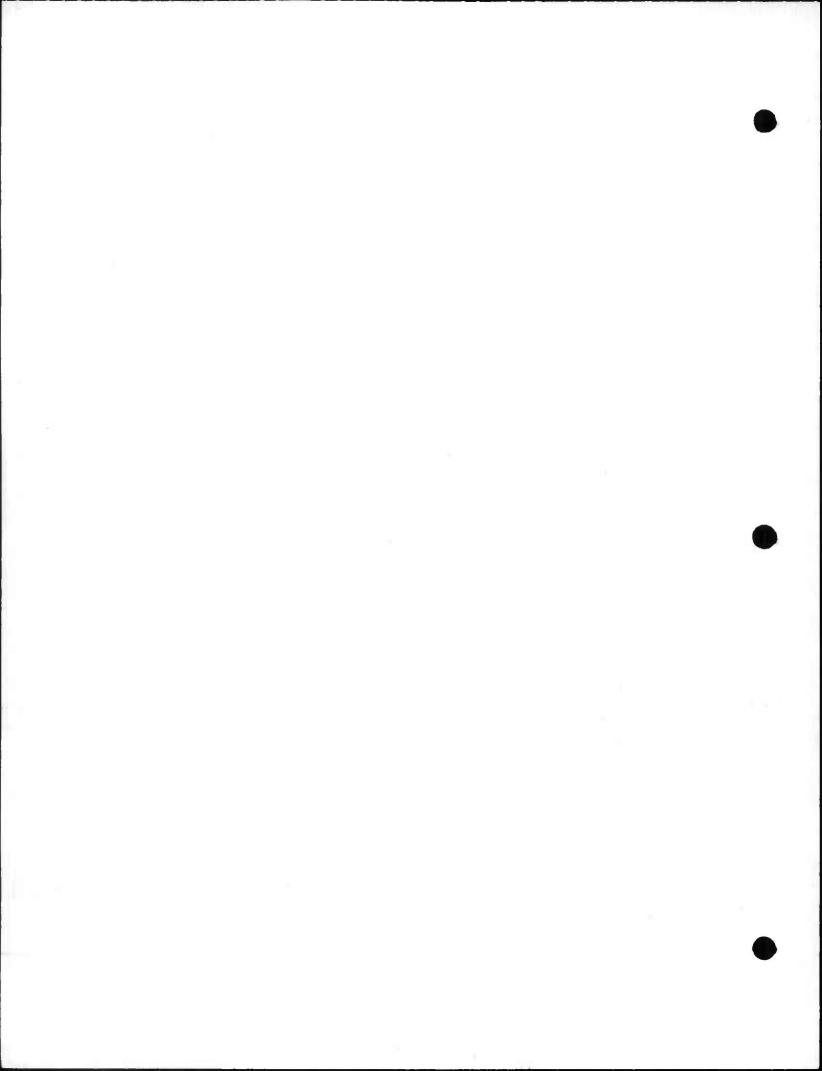
The certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

The marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

PHYSICIAN: The law requires that the death certificate be executed within N OF VITAL RECORDS, P.O. BOX 68760,

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| | REGISTRAR | | CE | RUFF | CATE OF | DEATH | RE | G. NO. | | |
|---------------|--|--|----------------------------------|-----------------------------|--------------------|---|--|---------------------|----------------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF D | | | 3. TIME OF DEATH |
| | LAURA | SUTTO | V | | | | MONTH 8 | 31 | 1994 | |
| | 4. SOCIAL SECURITY NUMBER | | AGE (In yrs. las | t hirthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BI | | | THPLACE (State or Foreign |
| | UNKNUWN | 1 M 2 X F | 82 | | ONTHS DAYS | HOURS MIN. | (Month, Day, 12-31- | Year) | Cou | ntry) |
| | 9e. FACILITY NAME (If not institution, give street | et and number) | - 02 | | ab CITY TOWAL | OR LOCATION OF DE | | _ | | RYLAND |
| Œ | | | | | | | CAIN | | 9c. COUNTY OF | DEATH |
| DIRECTOR | TAYOR MANOR NURSING | HOULE | | | ELLICOI | T CITY | | | | |
| E I | 10e. STATE 10b. COUNTY | | | 10c. CITY, | TOWN OR LOCAT | TION | | | | 10d. INSIDE CITY |
| 붑 | MARYLAND | | | | RALTI | MORE CIT | 'V | | | LIMITS? 1X YES 2 □ NO |
| | 10e. STREET AND NUMBER | | | | | . ZIP CODE | | | 10a CITIZEN OF | WHAT COUNTRY? |
| H. | 1537 KINGSWAY ROAD | ١ | | | | 21218 | , | | | |
| FUNERAL | | 12. WAS DECEDENT E | VED IN II S AD | MED | 12 WAS DEC | | | - 1 | USA | |
| | 1 Never Merried 2 Merried | FORCES? 1 | YES 2 N | 0 | If yes, sp | ENDENT OF NISPAR ecity-Cuben, Mexice | n, Puerto Rican, | atc.) | RNO — 14. RA | CE — American Indian, ick, White, etc. |
| B√ | 3 XWidowed 4 Divorced | IF YES, GIVE WAR | OR DATES | | 1 TYES | 2 MO Specifi | <i>y</i> . | | | ecity: |
| <u> </u> | 15. DECEDENT'S EDUCA | | 16a, DE | CEDENT'S U | BUAL OCCUPATION | N N | 165 KIND | OF BURN | IESS/INDUSTRY | ACK |
| | (Specify only highest grade co | | (Gi | ve kind of wo Do NOT use | rk done during mo | st of working | TOOL TANKE | 01 00011 | icos/iiioos (A) | |
| 2 | ciamentary/secondary (0-12) | College (1-4 or 5+) | | | , | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Lest) | | | OMEST | 10 | 18. MOTNER'S NA | 100° 00° A ANI-A-M | 14.140 | | |
| | ROBERT W. CARPEN | TTED | | | | | MC (FIRST, MIDDIN, | _ | | |
| BE | 19a, INFORMANT'S NAME (Type/Print) | TER | 106 | MAILING A | DDBECC (Ct | EMMA | 2 | | COBER | |
| 임 | JAMES T. HAYNIE | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION | | | | | VENUE, E | | | | |
| | 1 Buriel 2 Cremetion 3 Remove | al trom State | | | DISPOSITION (Na | EMETERY | DATE | | TION — City or | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | NSFE | CROWN | SATEL | | D ADDRESS OF FA | 011.1734 | CROW | NSVILLI | E, MARYLAND |
| | · (Ward | D. / | 3 | | JOSEPH | H. BROW | N JR. I | FUNER | AL HOM | E, P.A. |
| \dashv | 23. PART I. Enter the diseases, or cor | molications that a | 0,~, | th Dr. | 1913 W | . BALTIM | ORE ST. | ., BA | LTIMORI | E, MD.21223 |
| | ahock, or heart fallure. Lie | st only one cause | on each line. | stii. Do iio | t enter tha mo | de or dying, auc | n as cardisc o | or respire | tory srrest, | Approximate Interval Between |
| - 1 | iMMEDIATE CAUSE (Finsi disease or condition | 1 . | , | 1. | | 4 | / | | | Onset and Death |
| | resulting in desth) a. | ARTERIO | | | CARI | NO VASC | WAR | DI | seas | e. |
| | | DUE TO (O | R AS A CONSEC | UENCE OF): | | | | | | |
| CERTIFICATION | Sequentially list conditions, b. | DUE TO (O | R AS A CONSEQ | HENGE OF | | | | | | |
| F | if any, leading to immediate cause. Entar UNDERLYING | 502 10 (01 | AS A CONSEC | DENCE OF): | | | | | | |
| 윤 | CAUSE (Disease or injury that initiated events | DUE TO (OI | R AS A CONSEQ | UENCE OF | - | | | | | |
| Ē | resulting in desth) LAST | (| | | | | | | | į į |
| | d. | | | | | | | | | |
| _ [| PART il. Other significant conditions | contributing to de | sth but not re | suiting in | the underlying | cause given in | Part i. 24a. | WAS AN AU | | b. WERE AUTOPSY FINDINGS |
| DICA | | | | | | | | PERFORMI | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| ш 1 | | | | | | | _ ' ' ' | | | OF DEATH? |
| Σ : | DID TOBACCO USE CONTRI | BUTE TO CAUS | SE OF DEAT | TH YES | Пиог | UNCERTAIN | <u></u> | | | 1 123 2 100 |
| HYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | -3.1 10 CAO | | | (Check only one) | OTTCERIAN | , | | | |
| ဗ္ဗ | EXAMINER? | HOSPITAL: | 2/Outpetlant 2 | | THER: | | | | | |
| ΞI | 27. MANNER OF DEATH | 28e. DATE OF IN. | | 28b. TIME | | e 5 Residence | 28d. DESCRIBE | | IBY OCCUPED | |
| <u>a.</u> | | (Month, Day, | Year) | INJUR | ry wo | RK? | Zed. DEŞCHIBE | E NOW INJ | DRY OCCURED | |
| . 11 | 1 Netural 5 Pending | | | | | | | | | |
| | 1 Netural 5 Pending 2 Accident Investigation | | LILIRY — At box | no form etc | of footons office | | DOL LOCATION | | | |
| ED BY | 1 Netural 5 Pending | 28e. PLACE OF II building, etc | JURY — At hor (Specify) | ne, farm, str | et, tectory, offic | ' | 28t. LOCATION City or Town | | Number or Rural | Route Number, |
| | 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be datermined | 28e. PLACE OF II building, etc | (Specify) | | | | City or Town | n, State) | | Route Number, |
| | 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only) 1 CERTIFYING PNYSICIA | 28e. PLACE OF II building, etc | knowledge, dea | rth occurred | at the time, date | end place, and due | City or Town | n, State) end menne | r es stated. | |
| | 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only) 1 CERTIFYING PNYSICIA | 28e. PLACE OF II building, etc | knowledge, dea | rth occurred | at the time, date | end place, and due | City or Town | n, State) end menne | r es stated. | Route Number, |
| COMPLETED | 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only) 1 CERTIFYING PNYSICIA | 28e. PLACE OF II building, etc | knowledge, dea | rth occurred | at the time, date | end place, and due eath occured at the 29c, LICENSE NUN | City or Town to the cause(s) of time, data end p | end menne | r es stated. Jue to the ceuse | |
| BE COMPLETED | 1 Netural 5 Pending Investigation 3 Sulcide 8 Could not be determined 29e. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIA EXAMINER: | 28e. PLACE OF II building, etc | knowledge, dea | rth occurred | at the time, date | end place, and due eath occured at the 29c, LICENSE NUN | City or Town to the cause(s) of time, data end p | end menne | r es stated. Jue to the ceuse | (e) and menner ee stated. |
| COMPLETED | 1 Netural 2 Accident 3 Sulcide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO CO | 28e. PLACE OF II building, etc. AN: To the best of my On the best of exam | knowledge, dealination and/or in | nth occurred | at the time, date | end place, and due eath occured at the 29c, LICENSE NUM | to the cause(s) of time, deta end p | end menne | r es stated, lue to the cause | (e) and menner ee stated. |
| BE COMPLETED | 1 Netural 2 Accident 5 Pending Investigation 3 Suicide 4 Nomicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER | 28e. PLACE OF II building, etc. AN: To the best of my On the best of exam | knowledge, dealination and/or in | nth occurred | at the time, date | end place, and due eath occured at the 29c, LICENSE NUN | to the cause(s) of time, deta end p | end menne | r es stated, lue to the cause | (e) and menner ee stated. |
| BE COMPLETED | 1 Netural 2 Accident 3 Sulcide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO CO | 28e. PLACE OF II building, etc. AN: To the best of my On the best of exam | knowledge, dealinetion and/or in | nth occurred | at the time, date | end place, and due eath occured at the 29c, LICENSE NUM | to the cause(s) of time, deta end p | end menne | r es stated, lue to the cause | (e) and menner ee stated. |



Pages 1, 2, 3 should

permit.

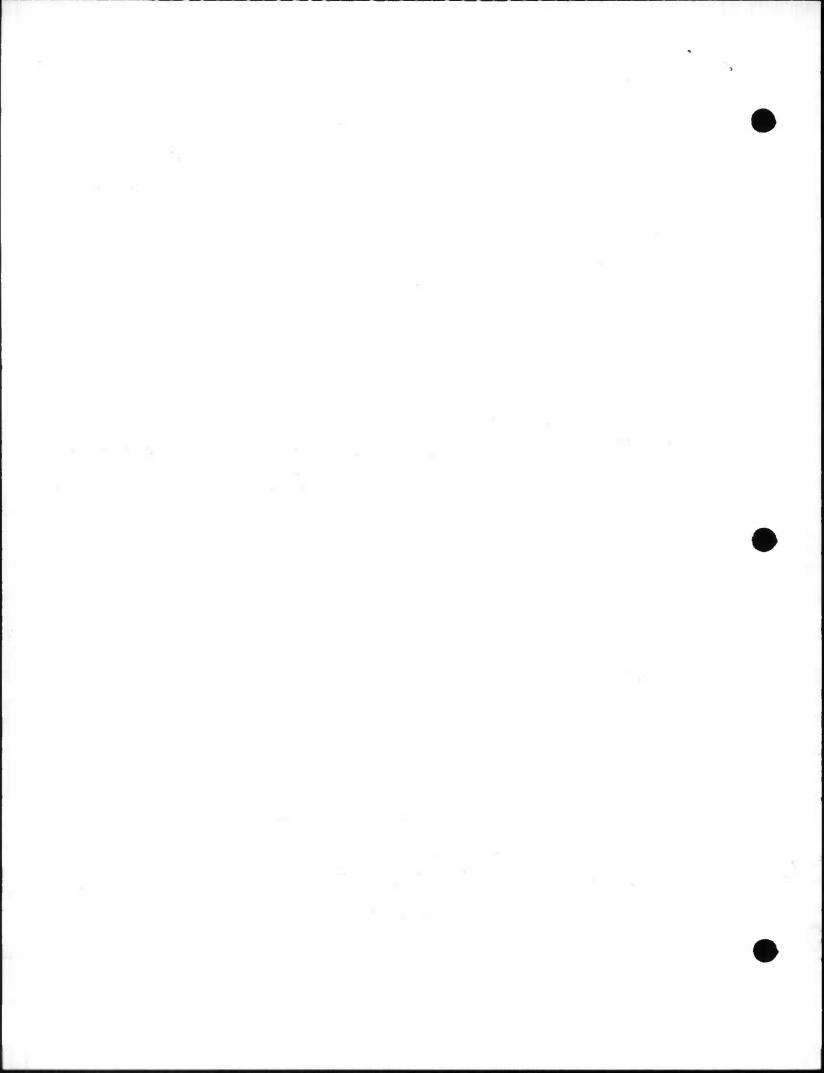
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Item 1 7FOR 11m 715, 9/9/ STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE LEGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH SEPT. 5, 1994 YEAR SILBERSTEIN 5:45 am ELSIE 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign SEPT. 9,1902 DAYS HOURS MARYLAND 218-34-1000 1 M 2XXF 91 9a. FACILITY NAME (if not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN IRECTOR MONTGOMERY POTOMAC VALLEY NURSING HOME ROCKVILLE RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE 1 YES 2 NO ā FUNERAL 10a. STREET AND NUMBER 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 21215 IISA 3610 CLARINTH ROAD 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—
 It yes, specify Cuban, Mexican, Puerto Rican, stc.)
 T YES 2 NO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried BY Specify: 3 Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 **BROKER** REAL ESTATE 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) GOLDBERG **JACOB GOLBERG** notitied at BE 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 MRS. CHARLOTTE LICHTENBERG 6256 CLEARWOOD ROAD BETHESDA, MD 20817 pe 20e. METNOD OF DISPOSITION 20b. PLACEAND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Cremetion 3 Rem must °°ARL'INGTON"-CHIZUK AMUNO BALTIMORE, MD 4 Donation 9+8-94 examiner FUNERAL SERVICE LICENT 21. SIGNATURE/O SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD BALTMORE, MD 21215 medical 23 PART LEnter the deseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition CEREBRAL THROMBOSIS DAY resulting in death) event, CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in desth) LAST Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL ULTI-INFARCT any DEMENTIA 1 YES 2 NO OF DEATH? Shows ESSENTIAL HYPERTENSION 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) tem **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ng Nome 5 - Reeldence 8 - Other (Specify) 6 27. MANNER OF DEATH 26e. DATE OF INJURY 28b. TIME OF 26c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked, 1 Natural 1 YES 2 NO BY Investigation Accident 2 PLACE OF INJURY — At home, term, street, tectory, office building, stc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 4 Nomicide 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner ea stated. 2 MEDICAL EXAMINER: On the b ation and/or investigation, in my opinion, death occured at the time, date end place, and due to the ceuse(s) end menner as stated. TO THE HOSPIT TO THE FACES DE filed within 296. SIGNATURE AND TITLE OF CENTERER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE thysician 1808 9 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) Type, Print) MONTROSE

32 REGISTRAR'S SIGNATURE



1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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| | | 4. SOCIAL SECURITY NUMBER 578-46- 9408 | 5. SEX | | _ | t birthday) | IF UNDER | 1 YEAR | IF UNDER 24 HRS. | 7. DATE (Month |
|--|---------------|--|--|------------------------|----------|---------------|-------------------|----------------|--|-------------------|
| PM | 1 3 | | 1√1 M 2 □ F | 8 | 7 | YRS. | | | | DE |
| 3 should | Œ | 90. FACILITY NAME (If not institution, give HOLY CROSS HOSP) | | | | | | | ER SPRI | |
| 1, 2, | СТОВ | RESIDENCE OF DECEDENT | | | | | | STUV | EK SEKI | NG |
| Sages | DIREC | 10a. STATE 10b. COUN | | | | 10c. CIT | Y, TOWN | | | |
| permit. Pages | | | ONTGOMERY | | | <u> </u> | | | ER SPRI | NG |
| 18i | FRAL | 9811 ARBOR HILL | DRIVE | | | | | 101 | . ZIP CODE | 20903 |
| Z15-UUZU attending physician. se as the burial-transit | BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE W | | | MED | | If yes, sp | ENDENT OF HISP/ ecity Cuban, Mexic 2 NO Spec | an, Puerto I |
| attending use as the | 윤 | 15. DECEDENT'S ED (Specify only highest grad | | | 16a. DE | CEDENT'S | USUAL C | CCUPATIO | ON st of working | 16b. |
| 10 P | COMPLETE | Elementary/Secondary (0-12) | College (1-4 or 5 | ·) | life. | Do NOT us | se retired.) | | | |
| the hospital detached to | ME | 17. FATHER'S NAME (First, Middle, Lest) | | | | FOR | RIER | | 18. MOTHER'S N | 1100 00 1 |
| by the | E CC | LEIB | | | SHA | FFER | | | LE | |
| MAKYLAND retained by the hospit 5 should be detached | 18 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | S (Street e | nd Number or Rura | |
| be reta | ٤ | MRS. ROSE SHAFF | ER | | | 981 | l AR | BOR | HILL DR | IVE, S |
| e 6 may be ector, page | | 20a. METHOD OF DISPOSITION 1 XBurlal 2 Cremetion 3 Rec | movel from State | | | NO OATE | | | me of AMUNO- | DATE |
| Page 6 m. I director, | | 4 Donation 5 Other (Specify) 21. SIGNATURE OF BUNERAL SERVICE L | ICEMBEE O | - | AKLI | NGIO | | | | |
| ALLIMORE, death. Page 6 may be s funeral director, page L. | | · Lotto 7 | A Gi | 44 | 7 | | | | LEVIN REISTER | |
| after after D | | 23. PART I. Enter the diseases, or | complications the | t cause | the de | ath. Do r | | | | |
| n 24 in the ation, | | shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. CAR |); A-(| ach line | ALC DIENCE OF | EST | | | |
| O. DOA 00/00, certificate be executed within physician and complete prior to burial, crem | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST | a ALZI | TEN | CONSEC | NUENCE OF | Dis | RD10 EAS | VASCUL E | AR |
| The death of the attend of Mental Hy Initiary, or | | | d | | T = 11. | | | | | |
| that the the that had by the that and we had a lead of the that we had | | PART II. Other algnificant condition | na contributing to | desth b | ut not n | esulting | In the U | nderlying | g cause given li | ı Part I. |
| | Ē | | | | | | | | | _ |
| w requirer been sign or, of Head | | | | | | | | | | _ |
| The un to hear to bept on 23 | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | | | 26. PL | ACE OF DEATH (C | heck only on |
| SICIAN: The Certificate the State | 1 6/2 1 | 1 YES 2 NO | HOSPITAL: | ER/Outp | atient 3 | □ DOA | OTHE | | e 5 🗆 Residence | 6 Othe |
| 2 光祖 4 篇 | | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF (Month, D | | | 28b. TIM | E OF IURY M | 28c. INJ WO | RK? | 28d. DES |
| OR ATTENDING DRECTOR Any Types after death | Exeb By | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined | 26e. PLACE O | F INJURY etc. (Spec | — At ho | me, ferm, | street, fac | tory, office | | 28f. LOC. |
| E 10 = | Jan 1 | emel | SICIAN: To the best of IER: On the basis of e | | | | | | | |
| 五五百四 | BE CO | 296/SIGNATURE AND TITLE OF CENTIFE | en) Su | u | | 14 | Λ | | 29c. LICENSE NO | 1 4 |
| 265₹ | 2 | 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CAUS | SE OF DE | ATH (ITE | 4 27) (Type | . Print) | | 120 | 106 |
| | | | AN My 5 | | | | | AIR | 1/1) 4 | SACIL |

94 26453 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2. DATE OF DEATH MONTH DAY 3. TIME OF DEATH 6 PM 11 SEPTEMBER 1994 7. DATE OF BIRTH (Month, Day, Year) DEC. 30, 8. BIRTHPLACE (State or Foreign 1906 POLAND 9c. COUNTY OF DEATH MONTGOMERY 10d. INSIDE CITY
LIMITS?
THES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA 14. RACE — American Indian, Black, White, etc. WHITE 66. KIND OF BUSINESS/INDUSTRY FUR t, Middle, Maiden Surname) imber, City or Town, State, Zip Code) SILVER SPRING, MD 20903 20c. LOCATION — City or Town, State -94 BALTIMORE, MD & BROS., INC. N RD. BALTIMORE, MD 21215 ardiac or respiratory arrest, Approximate Interval Between

Onset and Death MMED

DISEASE 10 YRS 3 YKS

24a. WAS AN AUTOPSY PERFORMED? 1 TES 2 NO

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 TYES 2 NO

| | Other (Spec | Hy) | | | |
|------|-------------|-----|--------|---------|---|
| 28d. | DESCRIBE | HOW | INJURY | OCCURED | Ī |

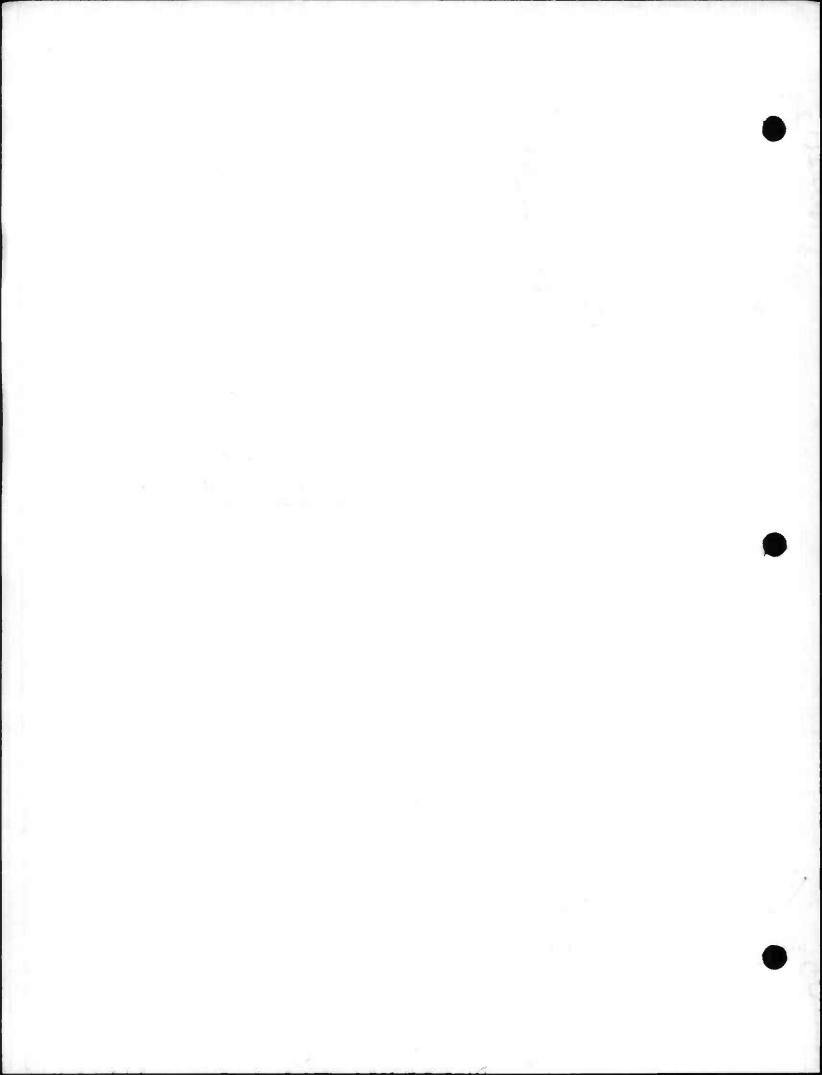
OCATION (Street end Number or Rural Floute Number, by or Town, State)

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|----------|---------|--------|-------|-----|--------|-------|------|--------|---------|--------|------|--------|-------|-----|
| pinion, | death | occure | d at | the | time, | date | and | place. | and | due | to | the | CRUSS | (s) |

| $\overline{}$ | OO - LICENSE ANDERS | _ |
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31. DATE FILED (Morrith, Day 100p) 0 9 1994 PEGISTRANS SIGNATURE.

CERTIFICATE OF DEATH



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withlism clours after death. Page 6 may be retained by the hospital or attending physician. | O THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should | be filed within 72 hours after death with the State Dept. of Health and Mental Hyguene prior to Dunal, cremation, of removal. | WPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|--|---|---|
| TO THE HOSPI | TO THE FUNER | be filed within | MPORTANT: |

CERTIFICATION

MEDICAL

PHYSICIAN:

COMPLETED

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DR

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ROSE

M.D

22. REGISTRAR'S SIGNATUR

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

SHELONITDA

94 26454 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1 DECEDENT'S NAME (First Middle Leet) 2. DATE OF DEATN 3. TIME OF DEATH YEAR HAMILTON SMITH 1994 SEPT 8:21 PM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year 5 SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS tXXM 2 F 243-40-3974 YRS 9 N.C 61 6 9e. FACILITY NAME (If not institution, give street end number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR MARYLAND GENERAL HOSPITAL BALTIMORE, CITY 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE, MARYLAND 1 X YES 2 | NO MARYLAND FUNERAL 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4011 MORTIMER AVENUE 21215 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or Noif yea, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: t4. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 1) Never Married 2 Merried ВҰ soB"Tack 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig Elementary/Secondary (0-12) College (1-4 or 5+) 12th JARITORIAL Janitoria UNIVERSAL SECURITY INST 17, FATNER'S NAME (First, Middle, Last) te. MOTHER'S NAME (First, Middle, Maiden Surname FRANK C. SMITH. ALMA CHISLOM BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 9 Sequoia SEGUORIA AVE HARRY E. SMITH , BALTIMORE, MD 3602 21215 20e. METNOD OF DISPOSITION

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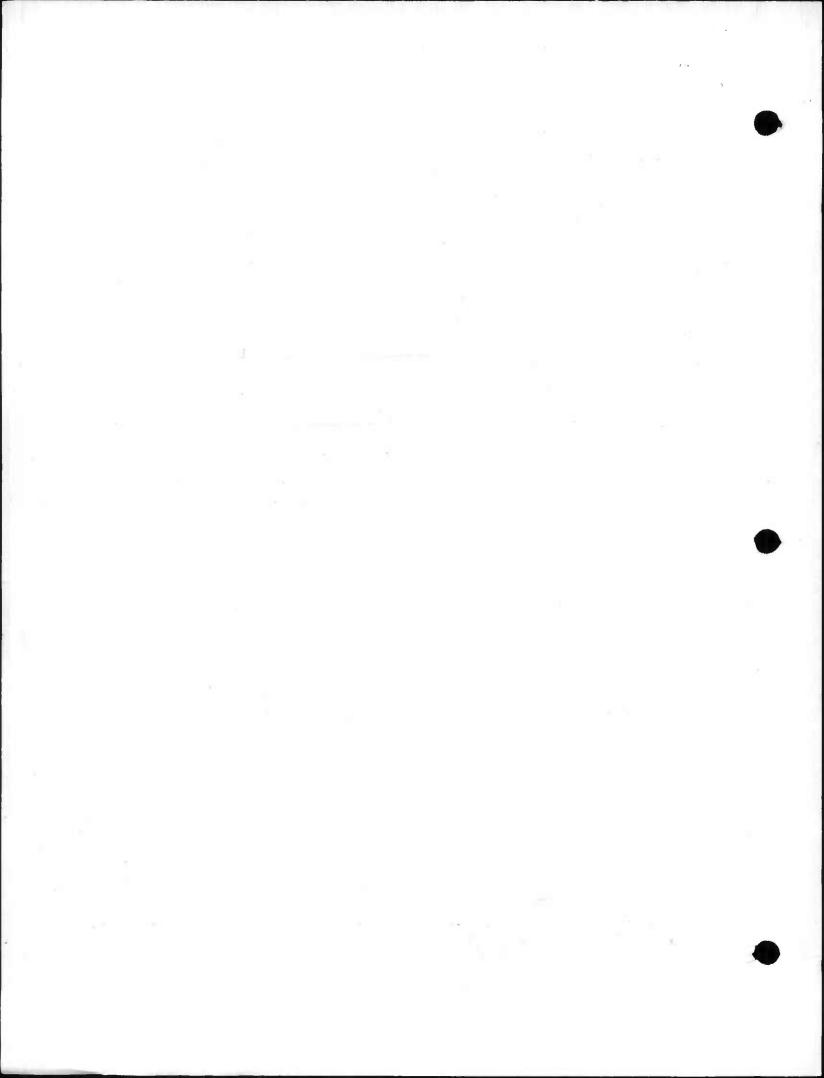
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Buriet 2 □ Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of PORT FOR SOME PARK) CEMETERY 9/10 ROCKY MT., N.C. 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FUNERAL HOME, WEST 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, 4300 WABASH AVENUE BALTO., MD Approximata ahock, or heart failure. List pnly one cause on each line. interval Between IMMEDIATE CAUSE (Final **Onset and Death disease or condition resulting in death) e. SEPSIS, DUE TO BACTERIAL ENDOCARDITIS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events reaulting in death) LAST PART ii. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE t TYES 2 □ NO OF DEATH? 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one HOSPITAL: OTHER: t TYES 2 NO 1 | Inpatient 2 | ER/Outpetlent 3 | DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28e, DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 🔲 Natural м 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY - At home, ferm, street, fectory, office 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner ee stated. 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) BE

c/o MARYLAND GENERAL HOSPITAL

1994

SEPT. 6,



| 020 | physician. |
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| BALTIMORE, MARYLAND 21215-0020 | death. Page 6 may be retained by the hospital or attending physician |
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dear of Health and Mental Hygiene prior to burial, cremation, or removal.

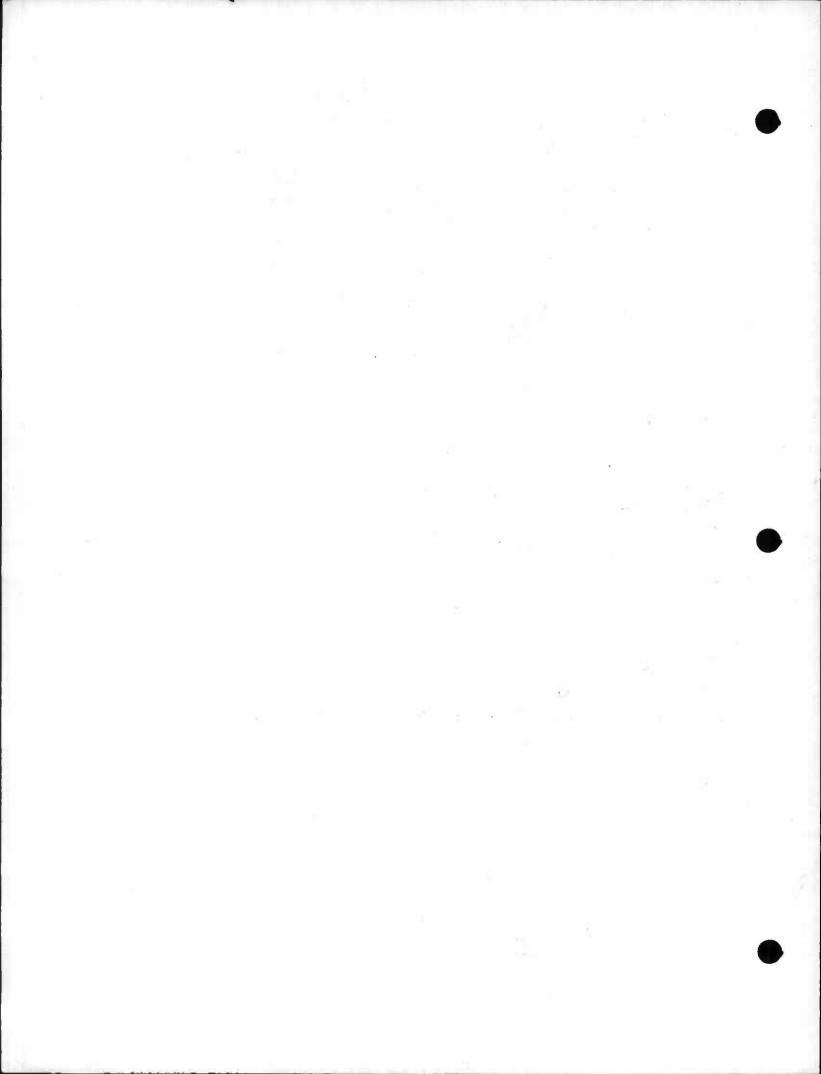
IMPORTANT: If tem 28 is marked.

| | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO. |
|--------------|--|
| 1 | 1. DECEDENT'S NAME (FIRST, MIDDIN, LAST) PAUL GNAGEY STANTON 2. DATE OF DEATH MONTH DAY YEAR 99 08 94 01:SI AM |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 1 M 2 F 8. AGE (In yrs. last birthday) 1 M M 2 F 8. AGE (In yrs. last birthday) 1 M MONTHS 1 DAYS |
| TOR | 90. FACILITY NAME (If not institution, give street and number) St Agner Hortilal — Mad 7-South Baltimure Besidence of deciding |
| DIRECTOR | 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND BALTIMORE CATONSVILLE 1 □ YES 2 ☑ NO |
| FUNERAL | 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| ВУ | 11. MARITAL STATUS 1 Never Merried 2 M Merried 1 PES, OIVE WAR OR DATES 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 PES 2 NO Specify: 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No-Bleck, White, etc.) 14. RACE — American Indien, Bleck, White, etc. 15. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No-Bleck, White, etc.) 16. RACE — American Indien, Bleck, White, etc. 17. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No-Bleck, White, etc.) 18. RACE — American Indien, Bleck, White, etc. 19. YES 2 NO Specify: WHITE |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondery (0-12) 12 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY WESTERN UNION |
| BE CON | 17. FATHER'S NAME (First, Middle, Lest) JAMES URBAN STANTON 18. MOTNER'S NAME (First, Middle, Meiden Surname) ANNA GNAGEY |
| TO | 196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) MILDRED STANTON (WIFE) 607 HILLTOP ROAD CATONSVILLE MARYLAND 21228 |
| | 20e. METHOD OF DISPOSITION 1 X Buriel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) |
| | 4 Donation 5 Dither (Specify) GRANTSVILLE CEMETERY 09-13-94 GRANTSVILLE MARYLAND 21. SIGNATURE OF UNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY LEROY M & RUSSELL C WITZKE FUNERAL HOMES |
| | 23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory street, Approximate |
| | ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death |
| ERTIFICATION | disease or condition resulting in death) a. Questions ble candiae awilydowns Due to (or as a consequence of): Coronary Artery brsease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): |
| 2 | PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PRODINGS PERFORMED? AMALABLE PRIOR TO |
| MEDICA | (2) Ca- FT il Stone Stone (2) IT belominal Hortic Precuryon 1 VES 2 NO COMPLETION OF CAUSE OF DEATH? |
| AN | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO |
| * | WAS CASE REFERRED TO MEDICAL EXAMINER? 1 SCYES 2 NO 26. PLACE OF DEATH (Check only one) OTHER: 1 Superient 2 ER/Outpatient 3 DOA 4 Nursing Nome 5 Residence 6 Other (Specify) |
| ВУ РНУ | 27. MANNER OF DEATH 289. DATE OF INJURY (Month, Day, Year) 289. TIME OF INJURY (Month, Day, Year) 280. TIME OF INJURY (Month, Day, Year) 280. TIME OF INJURY (Month, Day, Year) 280. TIME OF INJURY (Month, Day, Year) 280. TIME OF INJURY (Month, Day, Year) 1 YES 2 NO |
| 딢 | 3 Suicide 6 Could not be 4 Nomicide 6 Could not be determined City or Town, State) 28s. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) |
| COMPLE | 29s. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner se stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner se stated. |
| O BE C | 296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) D 41836 Scpt 8, 1994 |

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

SEP U9 1994



| | | | G-film 715 p | er F.H 9/9 | 9/94 P.C | | 94 | | | |
|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| | | FOR STATE REGISTRAR | STATE OF MARYLAND / | DEPARTMENT OF ERTIFICATE OF | | MENTAL HYGIEN | | | | |
| | | 1. DECEDENT'S NAME (First, Middle, Last) | Gerard Marti SHADBOLT | n Shadbol | t | 2. DATE OF DEATH MONTH SEPT. 2 | 2 9 4 P | 3. TIME OF DEATH 4:54 A | | |
| pino | | 4. SOCIAL SECURITY NUMBER 219-62-7475 | 5. SEX 6. AGE (In yrs. last | YRS. MONTHS DAYS | HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 07/09/54 | a | IRTHPLACE (State or Foreign ountry) reland | | |
| , 2, 3 shor | TOR | 9a. FACILITY NAME (If not Institution, give UNIVERSITY HO RESIDENCE OF DECEDENT | | | IMORE C | | 9c. COUNTY (| OF DEATH | | |
| nit. Pages 1 | DIRECTOR | Maryland 106. COUNT | Y | 10c. CITY, TOWN OR LOC | Dundall | k | | 10d, INSIDE CITY LIMITS? 1 X YES 2 NO | | |
| nsit perm | FUNERAL | 1615 Elrino St | reet Apt. B | | 10f. ZIP CODE 21224 | 4 | 10g. CITIZEN | OF WHAT COUNTRY? | | |
| retained by the hospital or attending physician. 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should notified at once. | B⊀ | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. AF FORCES? 1 YES 2 IF YES, GIVE WAR OR OATES | II yes, | ECENDENT OF HISPA specify Cuban, Maxica ES 2 NO Specifi | NIC ORIGIN? (Specify Yes an, Puarto Rican, etc.) fy: | s or No— 14. F | RACE — American Indian, Black, Whita, atc. Specify: White | | |
| al or attended for use as | LETED | 15. DECEDENT'S EDI (Specify only highest grad Elamentary/Secondary (0-12) | completed) (G | CEDENT'S USUAL OCCUPA- iive kind of work done during i . Do NOT use retired.) | | 16b, KIND OF BU | | | | |
| retained by the hospits 5 should be detached notified at once. | COMPLET | 11th 17. FATHER'S NAME (First, Middle, Lest) | Tax | i Cab Dri | | Taxi S | | 9 | | |
| ed by the ed at | BE C | Robert Sha | | | | Anne McDo | | | | |
| | 2 | Mary Loretto Gube | | b. MAILING ADDRESS (Stree 256 Sulphur | | | | | | |
| death. Page 6 may be funeral director, page sxaminer must be n | | Mary Loretto Gubernatis 1256 Sulphur Spring Road Arbutus, MD 21 20a. METHOD OF DISPOSITION 1 Generation 3 Removed from State 4 Gonation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other piece) 4 Gonation 5 Other (Specify) Baltimore, | | | | | | | | |
| | | 21. SIGNATURE OF FUNERAL SERVICE LI | Mc Donald | Crema | and adoress of fa | ciety of | Maryla | and, Inc. | | |
| d in or re | | | | | | | | MD 21228 | | |
| d with ompletely fille I. cremation, event, the | | ehock, or heart fellure. IMMEDIATE CAUSE (Finel disease or condition resulting in desth) | a. Due To (OR AS A CONSE | eth. Do not enter the n | node of dying, suc | h ss csrdisc or resp | iratory arrest, | Approximate Interval Between | | |
| th certificate be executed within ending physician and completely I Hygiene prior to burial, cremat or other traumatic event, it | ERTIFICATION | ehock, or heart fellure. IMMEDIATE CAUSE (Finel disease or condition | a. /Kacl cryscs | DUENCE OF): | node of dylng, suc | h ss cardiac or respi | iratory arrest, | Approximate Interval Between | | |
| that the death certificate be executed with the deby the attending physician and completely th and Mental Hygiene prior to burial, cremat any Injury, or other traumatic event, it | U U | ehock, or heart feilure. IMMEDIATE CAUSE (Finel disease or condition resulting in desth) Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | a. DUE TO (OR AS A CONSECT. OUE TO (OR AS A CONSECT. OUE TO (OR AS A CONSECT. OUE TO (OR AS A CONSECT. OUE TO (OR AS A CONSECT. | DUENCE OF): | node of dylng, suc | h ss cardisc or respi | AUTOPSY | Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset | | |
| that the death certificate be executed with been signed by the attending physician and completely it. of Health and Mental Hygiene prior to burial. cremat shows any Injury, or other traumatic event. | MEDICAL CE | ehock, or heart feilure. IMMEDIATE CAUSE (Finel disease or condition resulting in desth) Sequentielly liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent conditions. | a. DUE TO (OR AS A CONSECT. OUE TO (OR AS A CONSECT. OUE TO (OR AS A CONSECT. OUE TO (OR AS A CONSECT. OUE TO (OR AS A CONSECT. | peth. Do not enter the not. DUENCE OF): QUENCE OF): GUENCE OF): | node of dylng, suc | Pert I. 24a. WAS AN PERFOR | AUTOPSY | Approximate Interval Between Onset and Death Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Death Onset and Death | | |
| Reat has been signed by the death certificate be executed with Reate has been signed by the attending physician and completely. State Dept. of Health and Mental Hygiene prior to burial, cremat Item 23 shows any Injury, or other traumatic event, it | MEDICAL CE | ehock, or heart feilure. IMMEDIATE CAUSE (Finel disease or condition resulting in desth) Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent condition DID TOBACCO USE CONT 25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 X XES 2 \(\) NO | DUE TO (OR AS A CONSECT. OUE TO (OR AS A CO | DUENCE OF): DUENCE OF): DUENCE OF): DUENCE OF): DUENCE OF): DUENCE OF): DUENCE OF): OTHER: | Ing ceuee given in | Pert I. 24e. WAS AN PERFOR | AUTOPSY | Approximate Interval Between Onset and Death Onset and Death 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? | | |
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| TTENDING PROTECTION TO THE THE CHARLE STREET OF STREET O | ED BY PHYSICIAN: MEDICAL CE | ehock, or heart feilure. IMMEDIATE CAUSE (Finel disease or condition resulting in desth) Sequentielly liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent condition DID TOBACCO USE CONT 25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 X XES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending | DUE TO (OR AS A CONSECT. DUE TO (OR AS A CONSECT. DUE TO (OR AS A CONSECT. OUE TO (OR AS A CO | DUENCE OF): DUENCE OF): DUENCE OF): DUENCE OF): DUENCE OF): DUENCE OF): DUENCE OF): DOA | UNCERTAIL UNCERTAIL Dome 5 G Raeldenca NJURY AT VORK? YES 2 NO | Pert I. 24a. WAS AN PERFOR 1 YES 2 N D Other (Specify) 28d. OESCRIBE HOW I STRUCK B City or Town, State) | AUTOPSY MED? I NO NJURY OCCURE! Y AUTO and Number or Ru | Interval Between Onset and Death Onset and Death 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 \(\sum_{Y} YES 2 \sum_{N} NO | | |
| this certificate has been signed by the attending physician and completely with the State Dept. of Health and Mental Hygiene prior to burial, crematived, or Item 23 shows any Injury, or other traumatic event. | BY PHYSICIAN: MEDICAL CE | ehock, or heart feilure. IMMEDIATE CAUSE (Finel disease or condition resulting in desth) Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent condition DID TOBACCO USE CONT 25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 X XES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29a. CERTIFIER (Check only) 1 CERTIFYING PHYS | DUE TO (OR AS A CONSECT. DUE TO (OR AS A CONSECT. DUE TO (OR AS A CONSECT. OUE TO (OR AS A CO | DUENCE OF): DUENC | UNCERTAII UNCERTAII DOME 5 GRasidenca NJURY AT VORK? YES 2 NO Itea | Pert I. 24a. WAS AN PERFOR 1 X YES 2 N | AUTOPSY RMED? P NO NJURY OCCURET W AUTO and Number or Ru AND Ru LIA | Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset Of Death? 1 Yes 2 No | | |

111

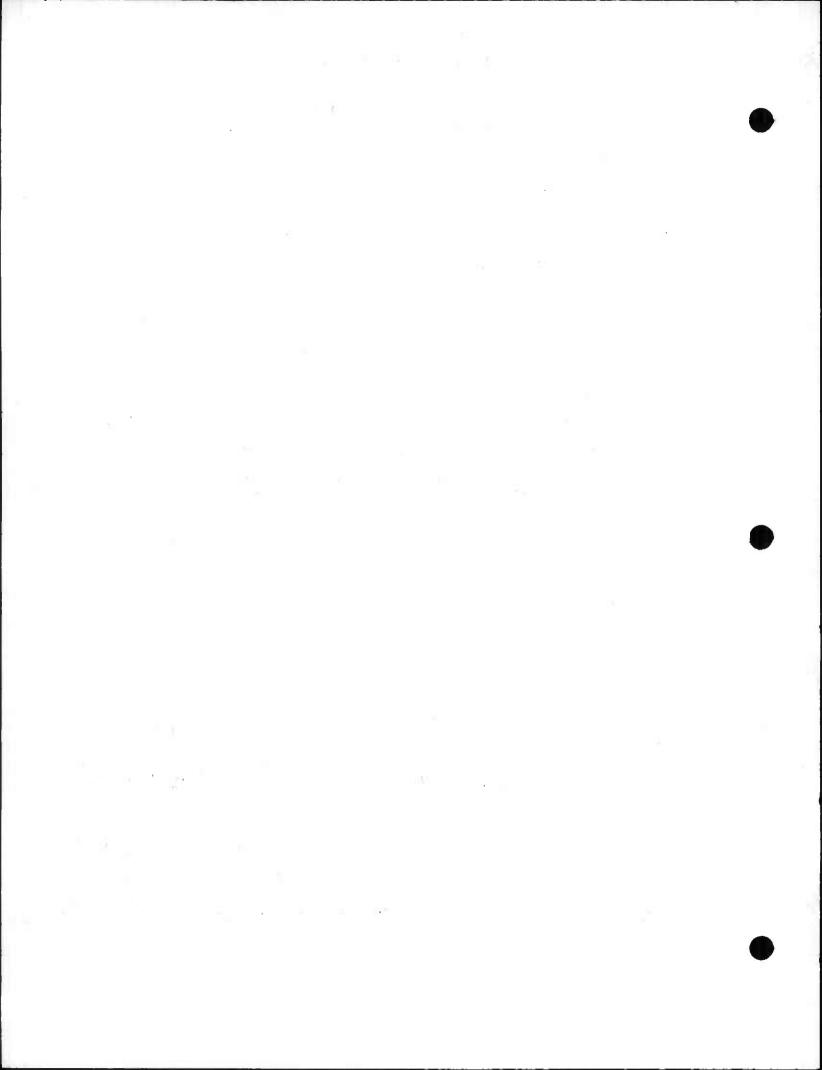
32 REGISTRAR'S SIGNATURE



2

SEP - 9 1994

Penn Street, Baltimore, Maryland 21201



3. TIME OF OEATN n/a

Approximata interval Between Onset and Daath

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?

REG. NO.

2. DATE OF DEATH MONTH

| | | PIPPIE REFF | TEA | | | | | | 5 | SEPT. | 7, | 1994 | n/a | | | | | | | | |
|---|---------------|--|---|---|--------------------------------|-----------|-------------|---------------------------|----------|--------------------------------------|------------------------|----------------------------|---|---|--|--|--|------|---------------------------------------|--|---|
| | | 4. SOCIAL SECURITY NUMBER 250 – 64 – 8383 | 5. SEX 1 M 2 F | 6. AGE (In yrs. 86 | last birthday) YRS, | IF UNDER | DAYS | IF UNDER 24 | HRS. | AR . 8, | TIN Marring (18 | s. BIRT | NPLACE (State or Foreign | | | | | | | | |
| hould | | 9a. FACILITY NAME (If not institution, give s | Λ | | | 9b. CITY | , TOWN C | R LOCATION | | | | COUNTY OF | | | | | | | | | |
| 2, 3 should | OR | 2003 Etting Stree | t | _ | | E | Balti | more | | | | N/A | | | | | | | | | |
| les 1, | DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | | | 10c. CIT | Y, TOWN | OR LOCAT | ION | | | | | 10d. INSIDE CITY | | | | | | | | |
| permit. Pages 1, | PIE | MARYLAND | n/a | | 1 | В | ALT | IMORE | | | | | LIMITS? | | | | | | | | |
| ·55 | FUNERAL | 100. STREET AND NUMBER 2003 ETT | ING S | TREET | | | 101 | ZIP CODE 212 | 07 | | 109 | CITIZEN OF UNITE | D STATE | | | | | | | | |
| 215-0020 attending physician. use as the burial-transit | BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT FORCES? 1 IF YES, GIVE W | YES 2 | | | If yes, spe | ecify Cuban, I | | ORIGIN? (Spe Puerto Ricen, | | 9— 14. RAC Blac Spec | CE — American Indian, ck, White, etc. city: BLACK | | | | | | | | |
| 215-0 attending | 8 | 15. DECEDENT'S EOU (Specify only highest grade | | 16a. | DECEDENT'S | USUAL O | CCUPATIO | ON st of working | _ | 16b. KINO | OF BUSINESS | S/INOUSTRY | | | | | | | | | |
| AND 21215-01 the hospital or attending detached for use as the once. | COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5 + |) | (Give kind of ville. Do NOT us | | | | | r | n/a | | | | | | | | | | |
| 3 & & Z | BE COI | 17. FATNER'S NAME (First, Middle, Last) CHAPMAN | SHERMAN | | | | | | HAR I | E (First, Middle, | Maiden Surner SHANN | | | | | | | | | | |
| be retained ge 5 should e notified | 10 | 190. INFORMANT'S NAME (Type/Print) RAYNETTE | TEAL | | 19b. MAILING 2003 | | S (Street a | | | ET, E | | | MD 21207 | | | | | | | | |
| tore for may rector, par | | 20e. METNOD OF OISPOSITION 1)(1)(2)(2)(3)(4)(1)(4)(1)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4) | oval from Stale | 20b. PLAC genetery, | CEAND DATE | of Dispos | CEM | _{me ol} ETERY | , | OATE | LANS | N — City of T D O W N E | | | | | | | | | |
| BALTIMG ter death. Page the funeral directival. | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MARCH FUNERAL HOME 1101 E. NORTH AVE. /BALTIMORE. | | | | | | | | | | | | | | | | | | | |
| E be executed within Jours after sician and completely filled in by the virot to burfal, cremation, or removal traumatic event, the medical | ION | 23. PART . Enter the diseases, or a shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, | List only one ceu | coused that se on each III O b Alo (OR AS A CONII (OR AS A CONII (OR AS A CONII (OR AS A CONII (OR AS A CONII (OR AS A CONII (OR AS A CONII | ine. | not anter | the mo | da of dying | , such a | as cardiac o | r reaplratory | y arrest, | Approximata interval Between | | | | | | | | |
| P.O. B th certificat ending phy il Hygiene p or other | CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | Secon | any | to | 70 | rtia | m s | ypn | NO. | e | | | | | | | | | | |
| ECORDS quires that the signed by the Health and M ows any Inju | | | | MEDICAL | MEDICAL | MEDICAL | MEDICAL | MEDICAL | MEDICAL | PART ii. Other significent condition | | | | _ | | | | _ 10 | MAS AN AUTOR PERFORMED? YES 2 N | | b. WERE AUTOPSY FINDING AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO |
| law as b bept. | Ä | DID TOBACCO USE CONTI | RIBUTE TO CA | | | | | UNCER | RTAIN | | | | | | | | | | | | |
| VITA JAN: The rtificate h ne State [or Item | Sic. | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | LACE OF DEAT | OTHE | R: | | | | | | | | | | | | | | |
| OF V PHYSICIAL this certif with the ted, or | PHYSICI | IN 1 Nativital 5 Pending | | | | | | | | | | | | | | | | | | | |
| 2 # S # 8 | TED BY | 2 Accident 3 Suicide 4 Nomicide M 1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Rown, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Rown, State) | | | | | | | | | | | | | | | | | | | |
| Print Office of the Print of th | COMPLET | 29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSI | CIAN: To the best of | | | | | | | | | | (a) and manner as stated. | | | | | | | | |
| TO THE HISP TO THE FUI | HB H | 296. SIGNATURE AND TITLE OF CERTIFIER | | 2- | | M | 2 | 29c. LICENS | | | | | D (Month, Day, Year) | | | | | | | | |
| 2 223 | 2 | 30. NAME AND ADDRESS OF PERSON WN | COMPLETED CAUS | SE OF DEATH (I | TEM 27) (Type, | land | 1 (1 | enera | Q t | tospi | Hol, | On | lpinae | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |

32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

31. DATE FILEO (Month, Day, Year) SEP 0 9 1994

DHMH-18 Ray 1/89

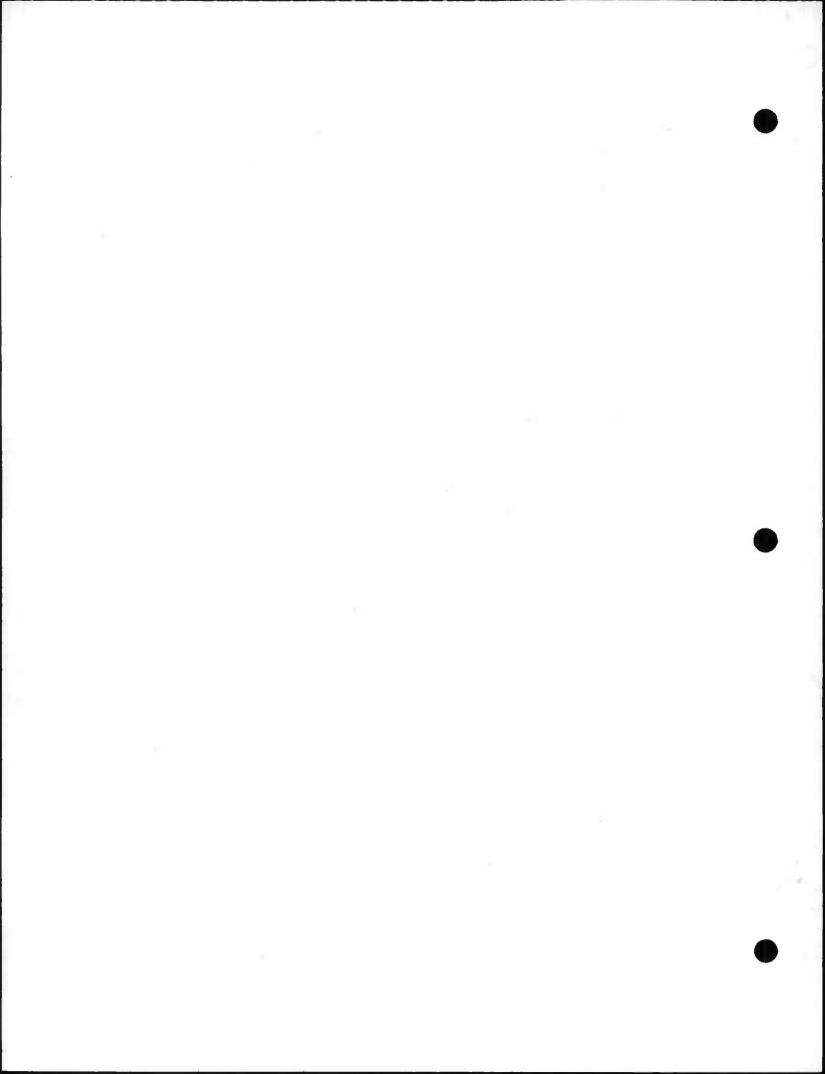
th. Page 6 may be retained by the hospital or attending physician. It is should be detached for use as the burial-transit permit. Pages 1, 2, 3 should learly director, page 5 should be detached for use as the burial-transit permit. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

| | Jean | Ę | |
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| | WIEDIN | pletely | remati |
| | executed | The first completely filled in by the attending physician and completely filled in by the fune | The companies of the State Dept of Health and Mental Hunjane prior to hurfal premation or removal |
| , | care be e | physician | a nrint tr |
| At. com | im cerum | tending p | al Hunian |
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SEP 0 9 1994

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|--|---------------|--|---------------------------|----------------------|---------------|--------------|-----------|-----------------|----------------------------|-------------------------------------|--------------|-----------------------|-------------------------------------|
| | | 1 - FOR STATE REGISTRAR | STATE OF I | MARYLAND / CE | DEPAR RTIF | TMENT | OF H | EALTH AN | ID MENT | AL HYGIEN | | | |
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | TE OF DEATH | | 3 | . TIME OF DEATH |
| | | GAIL | J. | | | TH | IOMA: | S | 1000 | nth o | AY 190 | YEAR O.A | n/a M |
| | | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last | birthday) | IF UNDER | | IF UNDER 24 H | es 7 DA | TE OF BIRTH | 0 | | ACE (State or Foreign |
| 10 | | 153-52-5503 | 1 🗌 M 2 💢 F | 35 | YRS. | MONTHS | DAYS | HOURS M | MA MA | Y I3,1 | 959 | N. (| CAROLINA |
| 3 should | | 9a. FACILITY NAME (If not institution, give str | reet and number) | | | | | R LOCATION C | OF DEATH | | 9c. COUNT | Y OF DEA | тн |
| 2, 3 | E | 7216 Ridge Road | | | | В | ALT | IMORE | | | | n/a | |
| - S | [[[| RESIDENCE OF DECEDENT | | | | | | | | | | | od, INSIDE CITY |
| Page | DIRECTOR | MARYLAND | n/a | | | | | IMORE | | | | | LIMITS? |
| ermit | | 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | | |
| physician. burial-transit permit. Pages 1, 2, | FUNERAL | 7216 RIC | | ROAD | | | | 2123 | 37 | | UNIT | | STATES |
| physician burial-tra | FU | 11. MARITAL STATUS XX Never Merried 2 Merried | FORCES? 1 | TEVER IN U.S. ARI | | 11 | yes, spe- | cify, Cuben, M. | SPANIC ORK exican, Pubr | GIN? (Specify Ye to Ricen, etc.) | e or No— 14 | I. RACE — Black, V | - American Indian, White, etc. |
| | B⊀ | 3 Widowed 4 Divorced | IF YES, GIVE V | WAR OR DATES | | 1 | YES | aX⊡Xno s | pecify: | | | Specify: | BLACK |
| aftend se as | 8 | 15. DECEDENT'S EDUC (Specify only highest grade of | ATION | 16e, DE6 | CEDENT'S | USUAL OC | CUPATIO | N | 1 | 6b. KIND OF BU | SINESS/INDUS | STRY | |
| the hospital or att detached for use once. | <u> </u> | Elementary/Secondary (0-12) | College (1-4 or 5 | +) life. | Do NOT us | e retired.) | - | t of working | | | | | |
| ospitz ched | COMPLET | 12 TH | - | u | nem | ploy | ed | | | m/a | | | |
| the horderst | 8 | 17. FATHER'S NAME (First, Middle, Last) | 6 | | | | | | | t, Middle, Malden | | | |
| ad by | 8 | EXIE THOMA | 12 | | | | | | ORRI | | ORTON | | |
| ours after death. Page 6 may be retained by the hospital or attending 1 in by the funeral director, page 5 should be detached for use as the or removal. medical examiner must be notified at once. | 9 | 190. INFORMANT'S NAME (Type/Print) CORRINE THO | MAS | | 124 | | | | | BALTIN | | | 1218 |
| page t be | | 20s METHOD OF DISPOSITION | | 20b. PLACE A | | _ | | | | | CATION — CIT | | |
| death. Page 6 ma funeral director, p | | A Buriel 2 ☐ Cremation 3 ☐ Ramo 4 ☐ Donetion 5 ☐ Other (Specify) | val from State | cerpetar NG | natory que | EMOR | IAL | PAR | 1 | | | | WN, MD |
| Pag ral dir | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MARCH FUNERAL HOME EAST | | | | | | | | | | | |
| death. Page funeral disconnected disconnected disconnected death. | | * Karen m. | 1. K | oger | | | | | | | | | |
| rs after of removal. | | 23. PART I. Enter the diseases, or complications that believed the death. Do not enter the mode of dying, such as cardisc or reepiratory arrest, ehock, or heert feliure. List only one cause on each line. Approximate interval Returner | | | | | | | | | | | |
| ours after our steemon or remon | | ehock, or heert fellure. L IMMEDIATE CAUSE (Finel | ist only one ceu | ise on each line. | | _ | 1 | Ī | 1 | 10 | 11 | | interval Between Onset and Death |
| ety fille | | disesse or condition reculting in deeth) e. I anutrition reculting in deeth) | | | | | | | | | | | |
| completely fal, cremati event, t | Ì | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| executed with and complet o burial, cren matic event | Z | Sequentially liet conditions, b. Cardio respiration | | | | | | | | | | | |
| e be execute sician and crior to burian traumatic | CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | |
| physician ne prior t | [일 | CAUSE (Disease or injury | OUE TO | (OR AS A CONSEO | NIEUCE DEL | | | | | | | | |
| death certificate attending physicate ental Hygiene pri | Ē | thet initieted events resulting in death) LAST | DOE 10 | (OH AS A CONSEC | DENCE OF | | | | | | | | Î |
| attending mtal Hygier ry, or oth | 8 | | | | | | | | | | | | |
| by the and Me | AL | PART ii. Other eignificant conditions contributing to deeth but not recuiting in the underlying ceuse given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS ANALABLE PRIOR TO | | | | | | | | | | | |
| signed by Health and DWS any | EDICAL | | | | | | | | | 1 TYES 2 | | CC | OMPLETION OF CAUSE F DEATH? |
| requires been sign of Heal | WE WE | | | | | | | | | | | | YES 2 NO |
| has been Dept. of P | ä | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | | | | | | |
| N: The lan cate has State Dep Item 23 | 2 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) OTHER: | | | | | | | | | | | |
| SICIAN: The partitionate the State | PHYSICIAN: | 1 YES 2 NO 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Recidence 8 Other (Specify) | | | | | | | | | | | |
| PHYSICIAN: The law requires that the libit certificate has been signed by the with the State Dept. of Health and Mind. or Item 23 shows any injury. | | 27. MANNER OF DEATH 1 Natural 5 Pending | 28e. DATE OF (Month, D | | 28b. TIM | E OF URY | WOR | K? | | ESCRIBE HOW I | NJURY OCCUI | RED | |
| ATN. | B | 2 Accident Investigation | 28a PLACE O | E IN ILIPY At hon | - form - | denote forte | | ES 2 NO | _ | 20171011 10 | | 200120 | |
| 42) | TED | 3 Suicide 6 Could not be 4 Homicide determined 28e. PLACE OF INJURY — At home, ferm, streef, factory, office building, etc. (Specify) 28e. CATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| E E E | PLET | 29s. CERTIFIER (Check only) CERTIFYING PHYSICIAN: To like best of my knowledge, dasth occurred at the time, data and place, end due to the ceuse(a) and menner se stated. | | | | | | | | | | | |
| SPITA NERA Nin 72 | COMPL | (Check only one) 2 MEDICAL EXAMINER | | | | | | | | | | | nd menner ee stated. |
| TO THE HOSPITA TO THE FUNERA De filed within 73 IMPORTANT. III | | 296. SIGNATURE AND TITLE OF CERTIFIER | Mr. 1 | | _ | - | T | 290 LICENSE | NUMBER | | 29d. DATE S | IGNED (M | onth, Pay, Year) |
| 는 보고 있다. 보고 하는 보고 | TO BE | Mulle () | Ille pa | m | (1) | | | 1)-20 | 637 | | D 9 | 7-9 | 4 |
| | F 1 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUS | SE OF DEATH (ITEM | 27) /āme | Drint) | | - | | | | | |



the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit is mental Hygiene prior to buriat, cremation, or removal.

Pages 1, 2, 3 should

permit.

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| RECO | requires that the death certific |
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| N OF VITAL RECORDS, P.O. BOX 68760 | PHYSICIAN: |
| NOISINIO | OR ATTENDING |
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has been signed by t Dept. of Health and

DIRECTOR: After this certificate hours after death with the State

31. DATE FILEO (Month, Day, Year)

SEY U 9 1334

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH : 45 DH homas Sephember 4. SOCIAL SECURITY NUMBE 7. DATE OF BIRTH 8. AGE (in vrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. B BIRTHPI ACE (State or Foreign (Month, Day, Yes 4.20, D YRS. 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Ba DIRECTOR 10 na RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 10 Dalto YES 2 NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 1019 Mar 21212 SA 9 U 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-11 MARITAL STATUS 14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 100 Specify: 1 Never Merried 2 Merried IF YES, GIVE WAR OR OATES BY 3 Widowed 4 Divorced Black COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEOENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Teacher's Aide 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First ones notified at BE (19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number of Rural Route Number 2 to. 20e. METHOD OF DISPOSITION pe 20b. PLACE AND DATE OF DISPOSITION /No 20c. LOCATION - City or Town. State OATE must Burlel 2 Cremation 3 Removal from State 9/13 ☐ Donetion 5 ☐ Other (Specify) OF FUNERAL SERVICE LICENSEE examiner 22 NAME AND ADDRESS OF FACILITY James A. Mo S 200 BY mes 701 aurens 121 medicai 23. PARTI Entar tha diseases, or complications that caused tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, ahock, or haart failura. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final the disease or condition_ DUE TO (OR AS A CONSEQUENCE OF): 8hr event, 1 reaulting in death) decubitue traumatic CERTIFICATION Sequantially ilst conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated avents resulting in death) LAST injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS lobe effusion /infiltrate AVAILABLE PRIOR TO CDMPLETION OF CAUSE OF DEATH? PERFORMED? shows any 1 TYES 2 T NO 1 [] YES 2 [] NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES PHYSICIAN: NO 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) item HOSPITAL: OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 0 27 MANNER OF DEATH 25e. OATE OF INJURY (Month, Day, Year) 26c. INJURY AT marked, 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 26t. LOCATION (Street end Number or Rural Route Number, City or Town, State) 50 COMPLETED 6 Could not be after 28 i TO THE HOSPITAL OR ATT
TO THE FUNERAL DIRECT
DE filed within 72 hours at
IMPORTANT: If Item 2 29e. CERTIFIER ledge, death occurred at the time, date end place, end due to the cause(s) end menner ee stated, SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (North, Day, Year) BE 2

(Type, Print)

32. REGISTRAR'S SIGNATURE

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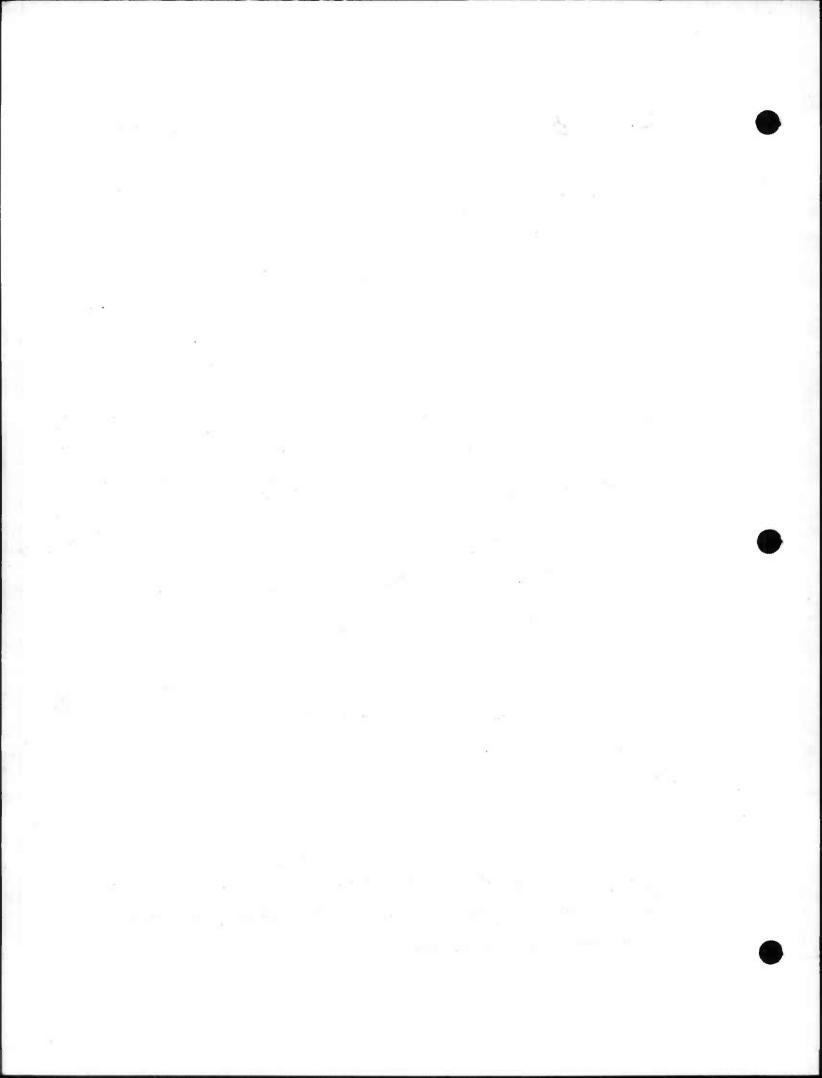
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| Se se | RECTOR: After this ours after death with the term 28 is marked |
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| | A ATTENDING PHYSICIAN: The law requires that the death certage. RecTOR: After this certificate has been signed by the attending wirs after death with the State Dept. of Health and Mental Hygitem 28 is marked, or Item 23 shows any Injury, or of |

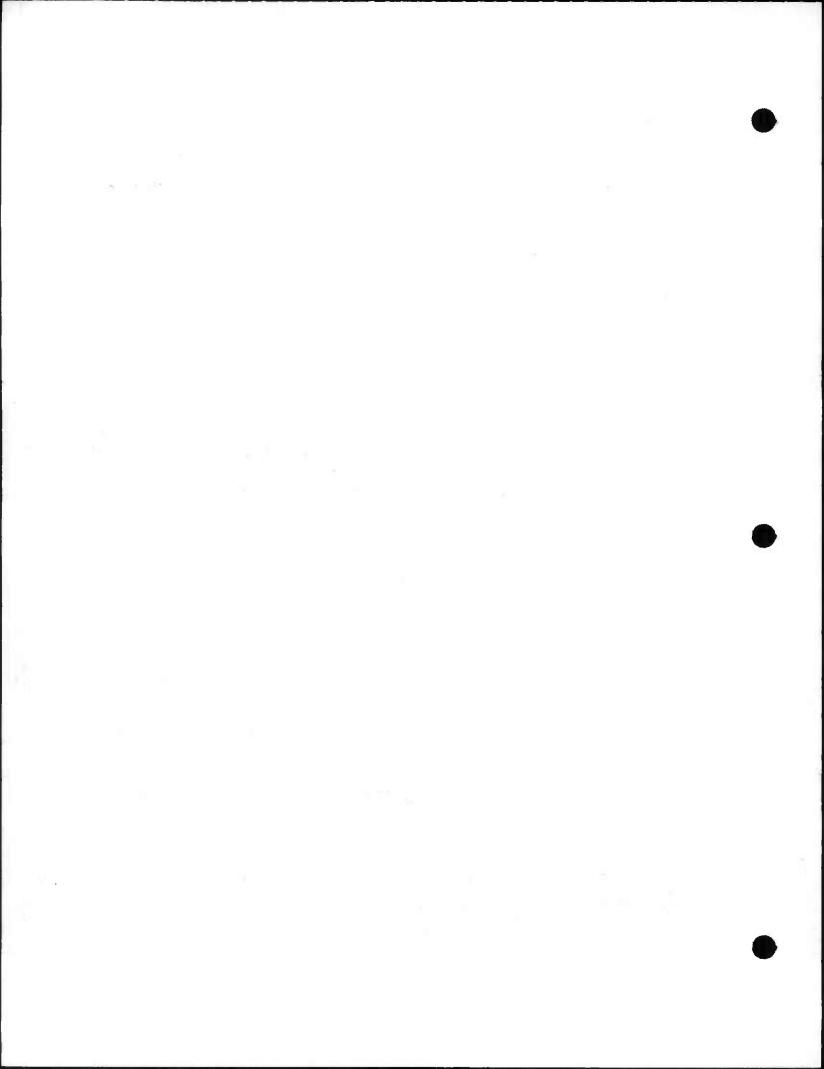
| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPAR | TMENT OF | HEALTH AND | MENTA | L HYGIEN | E | | | |
|---------------|--|---|--|-------------------------|---|----------------------------------|-------------------------------------|--|--|-------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle Last) | Tate | | | | 2, DATE | OF DEATH | 199 | 本 3 | TIME OF DEATH | |
| | 4. SOCIAL SECURITY NUMBER 213-64-8669 | 1 🗶 M 2 🗆 F 4 O | n yrs. last birthday) YRS, | IF UNDER 1 YEA | B HOURS MIN. | 09/ | be BIRTH (h, Day, Year) 10/53 | ACE (State or Foreign | | | |
| TOR | 98. FACILITY NAME (If not institution, give str Sinai Hospital RESIDENCE OF DECEDENT | eet and number) | | Balti | n or location of d | EATH | | 9c. COUNT | Y OF DEAT | TH | |
| DIRECTOR | 10e. STATE 10b. COUNTY Maryland - | | 10c. CIT | Y, TOWN OR LO | CATION Baltim | ore | | | d, INSIDE CITY LIMITS? XYES 2 \(\text{NO} \) | | |
| FUNERAL | 100. STREET AND NUMBER 2761 Fenwick Av | enue | | | 10f. ZIP CODE 2121 | | 109. CITIZEN OF WHAT COUNTRY? | | | | |
| BY FUN | 11. MARITAL STATUS 1 X Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2.4 NO | If yes, | epecify Cuben, Mexico ES 2 NO Specific | NIC ORIGI | | | Black, W | American Indian, //hita, atc. | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) | ATION completed) College (1-4 or 5+) | 16a. DECEDENT'S (Give kind of life. Do NOT us | work done during | NTION most of working | | . KIND OF BUS | | | | |
| O O | t7. FATHER'S NAME (First, Middle, Last) | 4 | и.и. | _ | dical | | usti | У | | | |
| BEC | Louis Jame | s Tate | | | | | Jane | , | nes | | |
| 0 | 198. INFORMANT'S NAME (Type/Print) Rosa J. Cook | | | | ck Aven | Route Num | ber, City or Town | , Stete, Zip Co | ode) | 21218 | |
| | 20s. METHOD OF DISPOSITION 1 | val from State Met | PLACE AND DATE | matory | , Inc. | 09/0 | 8 Bal | timo: | re. | MD | |
| | Dalwn F. McDo | McDmale | L | drema | tion So | ciet | y of | Mary | land | , Inc. MD 21228 | |
| 2 | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiretory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (ORAS A CONSEQUENCE OF): | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| A | PART II. Other significant conditions | it not resulting | In the underly | Part I. | | | | ERE AUTOPSY FINDINGS AILABLE PRIOR TO | | | |
| MEDIC | 1 TES 2 NO COM OF D | | | | | | | | | PMPLETION OF CAUSE DEATH? YES 2 NO | |
| PHYSICIAN: | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | | | | | | | |
| בַּ | 1 YES 2 NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Output 28e. DATE OF INJURY | ntient 3 DOA | OTHER: 4 - Nursing H | oms 5 - Residence | 8 🗆 Othe | er (Specify) | | | | |
| מו | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | INJ | M 1 YES 2 NO | | | 28d. DESCRIBE HOW INJURY OCCURED | | | | | |
| | 3 Suicids 8 Could not be detarmined 28s. PLACE OF INJURY — At home, farm, straet, fectory, offics building, etc. (Specify) 28s. PLACE OF INJURY — At home, farm, straet, fectory, offics City or Town, State) 28s. PLACE OF INJURY — At home, farm, straet, fectory, offics City or Town, State) | | | | | | | | | | |
| COMPLE | 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. | | | | | | | | | | |
| - BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | Medico | clical Resider 129c. LICENSE NUMBER 29d. DATE SIGNEO (Mornth, Day, March 129d.) DATE SIGNEO (Mor | | | | | | | | |
| | 30. NAME AND ADDRESS OF PERSON WHO | cil, smo | ai Hoog | | Baltimo | مد | MD, | 2/2 | 99 | | |
| | 31. DATE FILED (Month, Day, Year) SEP U 9 1994 | 32. REGISTRAR'S SIGNA | | | | | | | | | |
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| | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPART | | | MENTAL HYGIEN | | | | |
|---|---|--|---|-------------------------------|---|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Helen Johanna | Wolf | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH 8:30 A | | |
| 100000 | 216 26 2500 | SEX 6. AGE (In 90 | | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH | BIRTHPLACE (State or Foreign Country) | | | |
| LOR | 9s. FACILITY NAME (If not institution, give street 1501 Birch Court | and number) | | Bel | OR LOCATION OF DI | EATH | of DEATH | | | |
| DIRECTOR | 10e. STATE 10b. COUNTY | | | TOWN OR LOCA | | | 10d. INSIDE CITY LIMITS? 1 📉 YES 2 🗌 NO | | | |
| FUNERAL | 100. STREET AND NUMBER 341 Hornel St | treet | | 10 | 1. ZIP CODE 21224 | | OF WHAT COUNTRY? | | | |
| В | 11. MARITAL STATUS 12 1 | . WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT | 2 NO | It yes, s | CENDENT OF HISPAP secify Cuban, Maxice 2 NO Specify | n, Puerto Ricen, etc.) | | | | |
| COMPLETED | | ON spleted) College (1-4 or 5+) | 16a. DECEDENT'S U (Give kind of wo life. Do NOT use Housey | rk done during m retired.) | | 166. KIND OF BU | SINESS/INDUST | RY | | |
| | 9 17. FATHER'S NAME (First, Middle, Last) John Sebour | | Housey | OLK | 18. MOTHER'S NA Mary O | ME (First, Middle, Malden | | | | |
| TO BE | 190. INFORMANT'S NAME (Type/Print) Madelon Bennett | | 196. MAILING A | DORESS (Street | ourt Bel | Floute Number, City or Tow Air Md. 210 | n, State, Zip Coo | 10) | | |
| | 20e. METHOD OF DISPOSITION 1 Description 3 Removal 4 Denetion 5 Other (Specify) | from State came Sa | PLACE AND DATE OF tery, cremetory or othe ACTED HEA | rt of | Jesus Cen | 9-9-94 | cation – city Dundal | or Town, State | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENS LULIUM | Jule | | 6224 1 | Eastern A | er & Son I venue Balt | to.,Md. | | | |
| | 23. PART I. Enter the diseases, or comenock, or heart fellure. List IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) | Constant | STURNY | faclu | | n ss cerdiec or respi | ratory erreet, | , Approximate intervel Between Onset and Desth | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST b. Midval Nigning favron. OUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. Anni of chirties d. Anni of chirties | | | | | | | | | |
| ٦ | PART II. Other eignificent conditions co | ontributing to deeth bu | t not resulting in | the underlyin | g ceuse given in | Pert I. 24a. WAS AN PERFOF | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | | |
| YSIC | 1 TES 2 NO 1 | OSPITAL: Inpetient 2 ER/Outpet | Nent 3 DOA | THER: | e 5 🗆 Residence | 8 Other (Specify) | | | | |
| ВУ РН | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME INJUI | DF 28c. IN. IY WO | URY AT IRK? YES 2 NO | 28d. DESCRIBE HOW I | ED | | | |
| <u>ا</u> | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY - building, etc. (Specifi | - At home, tarm, str | eet, tectory, offic | | 28t. LOCATION (Street of City or Town, Stelle) | | tural Route Number, | | |
| 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data end place, and dus to the cause(s) end manner as stated. | | | | | | | | suse(s) and menner as stated. | | |
| TO BE C | 296. SIGNATURE AND TITLE OF CERTIFIER | in nip. | | | 29c. LICENSE NUN D1844 | 16 | ► 5cf. | GNED (Month, Day, Year) | | |
| - | 30. WAME AND ADDRESS OF PERSON WHO CO 301 St. Paul Pl. | Balto | ZUD 2 | rint) 1202 | GA | Ry B. 7 | Ruppe | est mo. | | |
| | SEP 0 9 1994 | 32. REGISTRAR'S SIGNAT | TURE | | | / | ,, | | | |



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

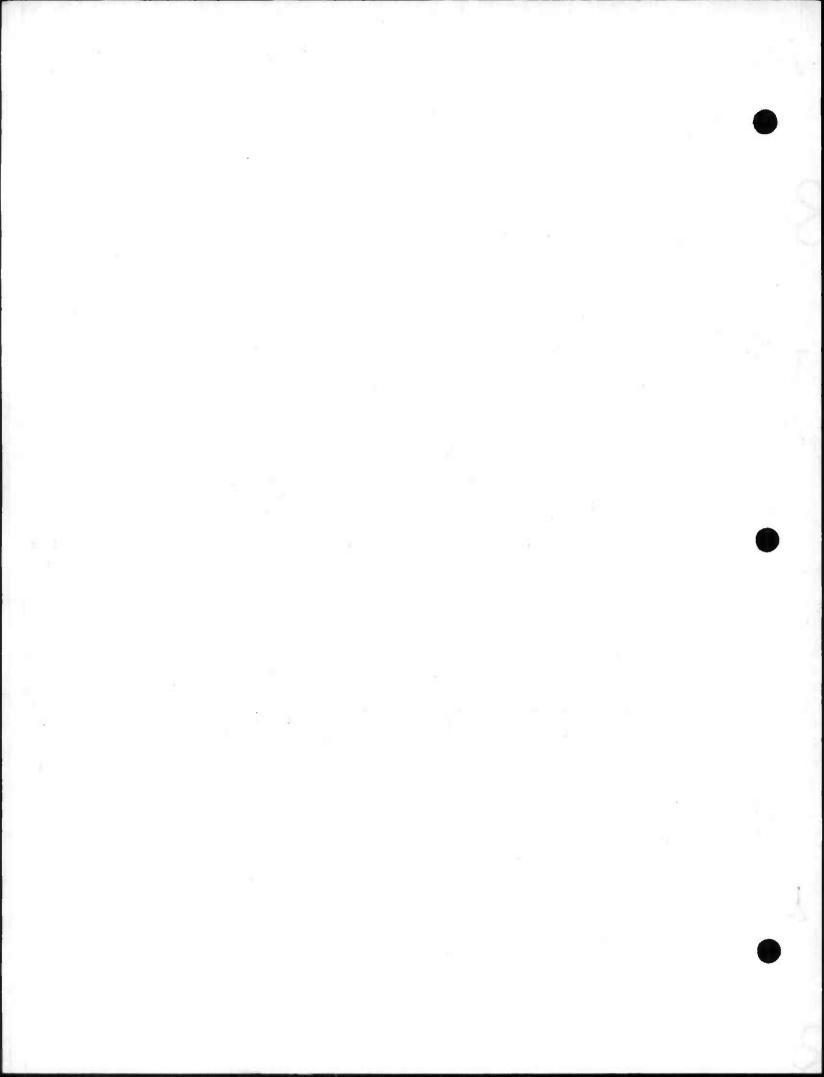
TO THE HOSPID AS LEADING PHYSICIAN: The law requires that the death certificate be executed within Lours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEHAU CHACURA HAVE this sertificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hober after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 Is, marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR |
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| _ | REGISTRAR | | CERTIFIC | AILO | PUEATH | REG. NO. | | | |
|--|--|-------------------------------------|--|------------------|-------------------------|----------------------------|------------------|--|--|
| 1 | 1. DECEDENT'S NAME (First, Middle, Lest) DOROTHY | M. ZARACH | HOWICZ | | | 2. DATE OF DEATH MONTH DA | V YEAR 94 | 3. TIME OF DEATH | |
| | 4. SOCIAL SECURITY NUMBER | | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | THPLACE (State or Foreign | | | |
| - 1 | 215-16-5435 | 1 🗆 M 2 💢 F | 71 YRS. MC | ONTHS DAYS | | 3-21-23 | Cou | RYLAND | |
| | 9e. FACILITY NAME (# not institution, give stre | net end number) | 9 | b. CITY. TOW | OR LOCATION OF DI | | 9c, COUNTY OF | | |
| Œ | JOHNS HOPKINS / | | | | IMORE | -AITI | SC. COUNTY OF | DEATH | |
| DIRECTOR | RESIDENCE OF DECEDENT | DATI VILL | 4 | DALI | THORE | | | | |
| Ĭ, | 10e. STATE 10b. COUNTY | | 10c, CITY, 1 | OWN OR LO | ATION | | | 10d. INSIDE CITY | |
| <u> </u> | MARYLAND BAL | TIMORE | | | | | | LIMITS? | |
| A | 10e. STREET AND NUMBER | | | | IOI. ZIP CODE | | 10g. CITIZEN O | F WHAT COUNTRY? | |
| EB | 6924 DELVALE PL | ACE | | | 21222 | | | USA | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVE FORCES? 1 2 | R IN U.S. ARMED | | ECENDENT OF HISPAI | NIC ORIGIN? (Specify Yes | or No.— 14. RA | CE — American Indian. | |
| | 1 Never Married 2 Merried | n, Puerto Rican, etc.) | | eck, White, etc. | | | | | |
| BÁ | 3 Widowed 4 Divorced | | | | ES 2 X NO Specif | , | | HITE | |
| ETED | 15. DECEDENT'S EDUCA (Specify only highest grade of | ATION ompleted) | 18e. DECEDENT'S US (Give kind of work | done during | TION nost of working | 16b. KIND OF BUS | INESS/INDUSTRY | | |
| ш | Elementery/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use n | etired.) | | | | [| |
| COMPL | 12 YEARS | | CLAIM | XAMI | NER | US GOV | ERNMEN | Τ | |
| 응 | 17. FATHER'S NAME (First, Middle, Last) | / 05000 | | | | ME (First, Middle, Maiden | | | |
| 띪 | NICHOLAS RASPE | / CE.SARE | | | JOSEPH: | | ACCI | | |
| 0 | 19e. (NFORMANT'S NAME (Type/Print) | 0110117.07 | | | | Route Number, City or Town | | | |
| | MR. ALBERT ZARA | | | | | BALTO. M | | | |
| | 20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Remove | ral from State | 20b. PLACE AND DATE OF C | placel . | Name of | 1 | CATION — City or | | |
| | 4 Donetion 8 Other (Specify) | | ARDENS OF | - | | | TO. CO | . MD. | |
| - 1 | The or romand spiriting lice | MIEE. | | KAC | AND ADDRESS OF FA | CILITY I FUNERAL | HOME | | |
| | KANUS HOUS | urushi | | | | K AVENUE | | . MD. 21222 | |
| 23. PART I. Enter the diseases, or complicatione that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, ehock, or heart feliure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition recuiting in death) Due To (OR AS A CONSEQUENCE OF): Due To (OR AS A CONSEQUENCE OF): Due To (OR AS A CONSEQUENCE OF): oue To (OR AS A CONSEQUENCE OF): oue To (OR AS A CONSEQUENCE OF): d. | | | | | | | | interval Batween Onset and Daath | |
| | | | | | | | | | |
| | PART II. Other significent conditions | contributing to deet | but not resulting in t | the underly | ng ceuse given in | | | 4b. WERE AUTOPSY FINDINGS | |
| CAL | | | | | | PERFOR | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | |
| 1 □ YES 2 NO | | | | | | | OF DEATH? | | |
| Σ | DID TOBACCO USE C | | | 1 YES 2 NO | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 26. PLACE OF DEATH (Check only one) | | | | | | | | | |
| SIC | | HOSPITAL: | | THER: | | | | | |
| 27. MANNER OF DEATH 27. MANNER OF DEATH 28. DATE OF INJURY (Month, Day, Year) 28. TIME OF INJURY AT WORK? M 1 YES 2 NO 28. DESCRIBE HOW INJURY OCCURED 28. DESCRIBE HOW INJURY OCCURED 28. DESCRIBE HOW INJURY OCCURED 28. DESCRIBE HOW INJURY OCCURED 28. DESCRIBE HOW INJURY OCCURED 28. DESCRIBE HOW INJURY OCCURED 28. DESCRIBE HOW INJURY OCCURED 28. DESCRIBE HOW INJURY OCCURED | | | | | | | NJURY OCCURED | | |
| | | | | | | | | | |
| | | | | | | | ni Route Number, | | |
| | 4 Homicide determined | building, atc. (S | (pecify) | | | City or Town, Stete) | | | |
| 3 Guide a Could not be determined 4 Homicide 4 Homicide 29e. CERTIFFIER (Check only one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner ea stated. | | | | | | | | | |
| | | | | | | | | e(a) and manner as stated | |
| | 286. SIGNATORE AND TITLE OF CENTIFIER | | | , | | | | | |
| | Street Ha | who my |) | | D 224 | - 0 | ▶ 9 F | ED (Month, Day, Year) | |
| - | STUART JACUBE MY | COMPLETED CAUSE OF | DEATH (ITEM 27) (Type, Pri | Sunta | 818 | Batto md | - 21a | 2 | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SI | | | | | | <u> </u> | |
| | SEP 0 9 1994 | in Denien | | | | | | | |



be detached for use as the bunal-transit be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 death. Page 6 may filled in by the completely DIVISION OF VITAL RECORDS, P.O. BOX 68760, that the death certificate be executed

Pages 1, 2, 3 should

permit.

once. notified be Hust examiner medical ŏ the cremation, event, n and com to bunal, traumatic the attending physician I Mental Hygiene prior to other 0 signed by the shows any been : has b Dept. 23 certificate ha itеm

OR ATTENDING PHYSICIAN:

this c.

After

DIRECTOR:

10

marked,

S

28

30. NAME AND AD

31. DATE FICED (MONT)

RESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 HERISTRAT'S SIGNATURAL

Vega

Francisco

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH DAY MIKE Angelopulas MAVROUDIS 10:45 PM 05 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 84 11-22-09 216-28-7769 1 1 M 2 | F Greece 9s. FACILITY HAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Johns Hopkins Bayview Hospital Baltimore City RESIDENCE OF DECEDENT 10s. STATE 10c. CITY, TOWN OR LOCATION 10b. COUNT 10d. IHSIDE CITY Maryland Baltimore 1 X YES 2 | NO FUNERAL 10e. STREET AHD HUMBER 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 616 S. Rappolla Street 21224 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPAHIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Maxican, Puarto Rican, stc.) 14. RACE — American Indisn, Black, Whits, stc. 1 Hever Married 2 X Married 1 YES 2 THO Specify: В Specify: 3 Widowed 4 Divorced White 18s. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIHD OF BUSINESS/INDUSTRY (Specify only high Elsmentary/Secondary (0-12) 9th College (1-4 or 5+) Proprietor Grocery Store 17. FATHER'S HAME (First, Middle, Last) 18. MOTHER'S HAME (First, Middle, Meiden Sumeme) Christos Angelopulos Anna Karayiannis BE 19s. IHFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
616 S. Rappolla Street, Baltimore, Md. 2 Chris Angelopulos 21224 20a. METHOD OF DISPOSITION
1 Burisl 2 Cremstlon 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Oak Lawn Cemetery 9-10 Baltimore, Md. 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUHERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Matthews Funeral Home matcheria 21 3021 Eastern Avenue, Baltimore, Md. 23. PART I. Enter tha diseasee, or complications that ceueed the death. Do not anier the mode of dying, such as cerdiac or reepiratory arrest, Approximata shock, or heart failure. List pnly one cause on each line. intarval Batwean IMMEDIATE CAUSE (Final Onsat and Daath disease or condition resulting in death) Preumonia Aspiration DUE TO (OR AS A CONSEQUENCE OF): Accident Cerebrovascular CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF if any, leading to immediate cause, Entar UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events raculting in daath) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO Atnal Fibrillation COMPLETION OF CAUSE DF DEATH? t | YES 2 | NO Diabetes Mellitis 1 YES 2 HO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOŞPITAL: OTHER: 1 YES 2 NO 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 - Hursing Homs 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Haturel 1 YES 2 NO ВҰ 2 Accident Investigation 28s. PLACE OF INJURY — At home, fsrm, strset, factory, office building, etc. (Specify) Suicids 281. LOCATIOH (Street and Number or Rural Route Number, City or Town, State) 8 Could not be PLETED 4 Homicide datsrminsd 29s. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and dus to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On this basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 94129 9-5-94 0

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page 5 should be

funeral director,

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31. DATE FILED (Month Day)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Dr. Ramesh Sabapathi 821 North Eutaw Street Baltimore, MAryland Suite 308

32. REGISTRAR'S SIGNATURE

Pages 1, 2, 3 should

permit.

burial-transit

physician

attending detached for use as the

94 26464 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH RODNEY ALAN **ADAMS** September 8 3:45P 84 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) October 19, IF UNDER 1 YEAR | IF UNDER 24 MIRS. 8. BIRTHPLACE (State or Foreign 212-46-9761 1 X M 2 - F 43 Maryland 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Maryland General Hospital Baltimore N/A RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10e. STATE 10b. COUNTY 10d. INSIDE CITY LIMITS? Maryland N/A Baltimore 1XX YES 2 □ NO FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5914 Meadowood Road 21212 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, stc. Never Married 2 Merried
Widowed 4 Divorced If yes, specify Cuben, Mexicen, Puerto Ric 1 YES 2 X NO Specify: BY Specify White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16h KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 5 + Grant Writer Hospital 17. FATHER'S NAME (First, Middle, Last 18. MOTHER'S NAME (First, Middle, Maiden Sumerne) Ħ Wilbert Charlton Adams Ora Louise New BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Mrs. U. L. Adams 5914 Meadowood Road Baltimore, Maryland 21212 be METHOD OF DISPOSITION 20e. METHOD OF DISPOSITION

1) Byriel 2 Cremation 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must ation 5 D Other (Spice "Druld" Ridge "Celletery 9/13 Pikesville, Maryland MATURE OF FUNDANJESPINICE LIGHISEE A MMS XII CAN Dennis Stephen Xenakis 22. NAME AND ADDRESS OF FACILITY MITCHELL-WIEDEFELD HOME examiner M00640 6500 York Road Baltimore, Maryland 21212 medical 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Finel the diseese or condition Cardiopulmanary Arrest Unknown resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): Sepsis CERTIFICATION Unknown Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury Aguired Immune Deficiency Unknown or other DUE TO (OR AS A CONSEQUENCE OF): that initieted eventa reaulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO shows any COMPLETION OF CAUSE OF DEATH? 1 TYES 2 XNO 1 YES 2 NO PHYSICIAN: Dept. 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 28c. INJURY AT WORK? 1 XX Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident DIRECTOR: An hours after desitem 28 is r 3 Suicide 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, 6 Could not be determined COMPLETED 29e. CERTIFIER

Thank and

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29h, SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 4 () annot

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31. DATE FILED (Month, Day, Year)

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32. REGISTRAR'S SIGNATURE

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FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR **CERTIFICATE OF DEATH** REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OFATH 3. TIME OF DEATH MILLARD BREEDEN 3:15 94 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 1 XM 2 - F YRS. LNE 21, 219-38-9248 1942 MARYLAND 9a. FACILITY NAME (If not institution, give street end number 95. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Harbor Hospital Baltimore 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Baltimore 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2001 Ashton St. 21223 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 XMerried 1 TYES 2 NO Specify: Spec/fv: В 3 Widowed 4 Divorced white ETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY /Specify Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Unemployed 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) ĕ Joseph Breeden Mary Nash BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2 Eva Weckesser 1004 Joh Ave., Balto., Md. e 20a, METHOD OF DISPOSITION
1 X Burlel 2 Cremetion 3 A
4 Donetion 5 Dotter (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must 9/06/94 Cedar Hill Cemetery Brooklyn, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSER examiner 22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elkridge, Inc. many au 5695 Main St. Elkridge, Md. 21227 medical 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory errest, shock, or heart fall are. List only one cause on each line. Approximate Interval Batween Onset and Death IMMEDIATE CAUSE (Final the disesse or condition resulting in death) SEPTICEMIA event, OUE TO (OR AS A CONSEQUENCE OF): LEFT THIGH CELLULITIS traumatic CERTIFICATION Sequentially list conditions OUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate CHRONIC LIVER DISEASE - NON INSULIN DEPENDENT cause. Enter UNDERLYING CAUSE (Disesse or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events DIABETES MELLITUS resulting in deeth) LAST 0 Injury. PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL AVAILABLE PRIOR TO any COMPLETION OF CAUSE 1 | YES 2 | NO OF DEATHS shows a 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\text{\text{\$\omega\$}}\) NO \(\text{\text{\$\omega\$}}\) SICIAN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The Party EXAMINER? HOSPITAL: OTHER 1 YES 2 NO 1 X Inpetient 2 | ER/Outpetient 3 | DOA me 5 🗆 Res 6 Other (Specify) PHY 27. MANNER OF OEATH 26s. DATE OF INJURY 26b, TIME OF 26c. INJURY AT WORK? 28d. OEŞCRIBE HOW INJURY OCCURED Month, Day, Year) 9 2 94 3:55 AM 1 Natural 5 Pending 1 YES 2 NO Investigation 2 Accident 26e. PLACE OF tNJURY — At home, farm, streat, tectory, office building. atc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) after the 28 is 6 Could not be ED 4 Homicide determined ᆿ Item 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(e) end manner as stated. COMPL TO THE HOSPITAL
TO THE FUNERAL I
be filed within 72 h
IMPORTANT: If II 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(s) and menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNEO (Month, Day, Year) BE Vines EUGOVID F. VINES MO 9/2/94 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3001 SOUTH HANDYER EUGENIO F. VINES MD BALTIMORE, MO STREET.

REG. NO.

FOR STATE REGISTRAR

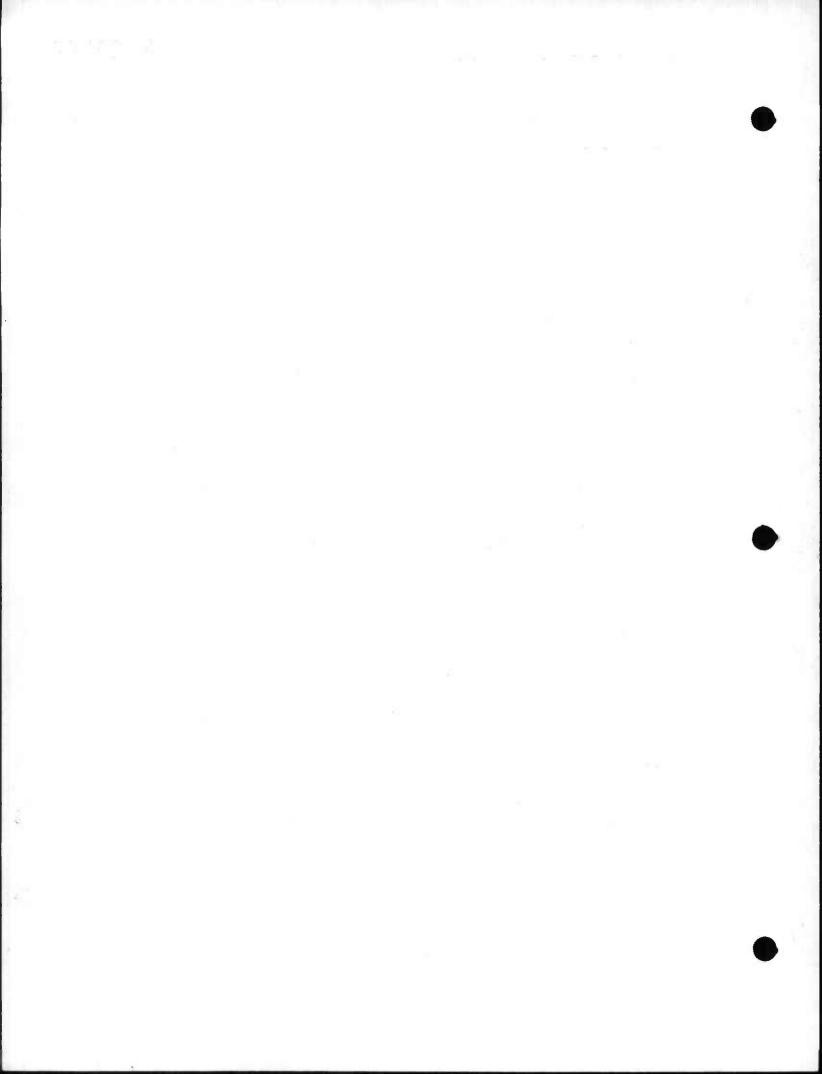
1. DECEOENT'S NAME (First, Middle, Last

BALTIMORE, MARYLAND 21215-0020

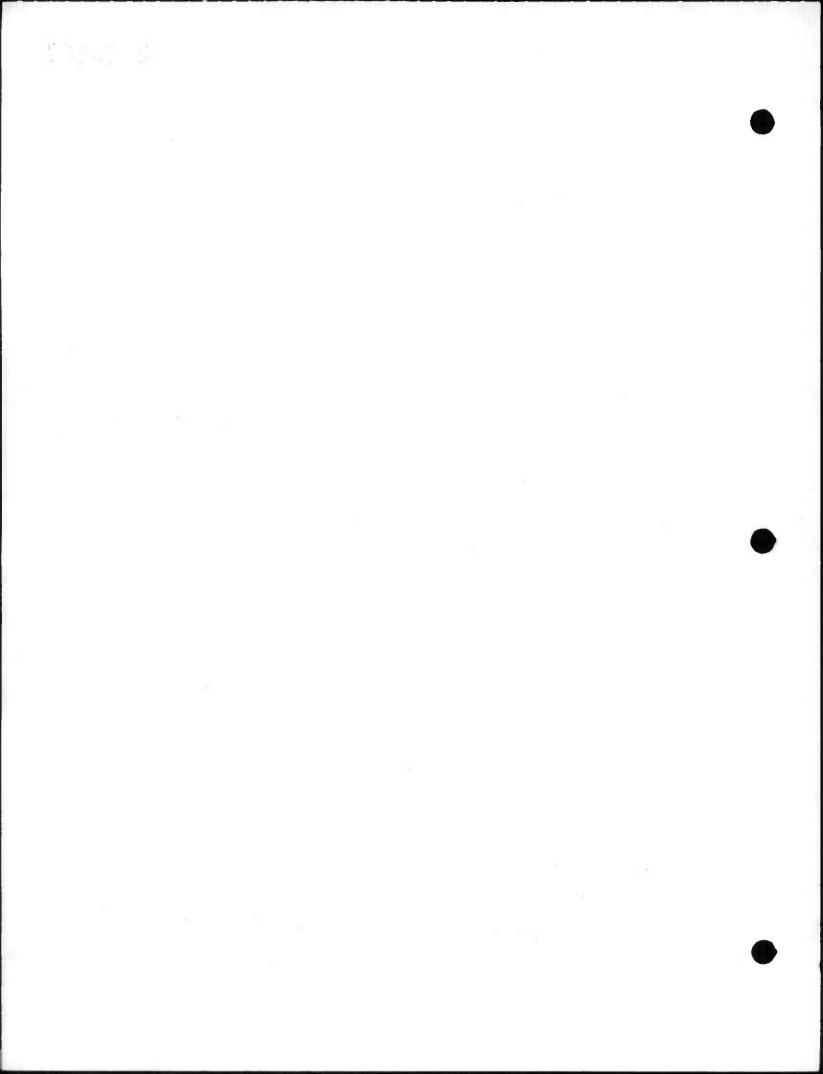
DIVISION OF VITAL RECORDS, P.O. BOX 68760

3. TIME OF DEATH 2. DATE OF DEATH MONTH YEAR SENNE 94 9 217-82-3230 6. AGB (In yrs last birthday) YRS. DATE OF BIRTH (Month, Day, Year) 1-26-64 & BIRTHPLACE (State or Foreign DAVE HOURS Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give stre et and number N OR LOCATION OF DEATH 9c. COUNTY OF DEATH taspita DIRECTOR MURISITU RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 30 1 YES 2 NO permit. FUNERAL STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 108 21229 London 11.S.A ve funeral director, page 5 should be detached for use as the bunial-transit retained by the hospital or attending physician. 11 MARITAL STATUS
1 Never Married 2 Married 14. RACE — American Indian, Black, White, atc. Specify: Black 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cyban, Maxican, Puerto Rican, stc.)
 T YES 2 SHO Specify ΒY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary ecopodary (0-12) College (1-4 or 5 +) Unknown 17. FATHER'S NAME (First, Middle, Last) 18 MOTHER'S NAME (First, Middle, Maiden Sumame) 76 2 BE notified MAILING ADDRESS (S Balto, 2 da enne 108 The 21229 endin ours after death. Page 6 may be pe METHOD OF DISPOSITION 200 PLACE AND DATE PEDISPOSITION (Name 9/13/ must Burial 2 Cremation 3 🗆 Ra 2 Donation 5 ☐ Other (Specify) ехатіпег narch 4300 filled in by the fion, or removal. 603 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate **IMMEDIATE CAUSE (Final** Onset and Death cremation, other traumatic event, the disease or condition_ LESJON) DUE TO (OR AS A CONSEQUENCE OF): signed by the attending physician and completely in Health and Mental Hygiene prior to burial, crematic reaulting in death) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): E HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be a g. FUNERAL DIRECTIOR. After this certificate has been signed by the attending physician is within 72 hours after death with the State Dept. of Health and Mental Hyriteins property. If any, leading to immediata cause. Entar UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reauiting in death) LAST PART ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 246. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 | YES 2 | 100 PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** AL: lent 2 ER/Outpatlant 3 DOA OTHER: 1 YES 2 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 9/9/9 L Natural м 1 YES 2 NO BY 2 Accident Al home, farm, street, factory, office 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29a. CERTIFIER 1 STIFYING PHYSICIAN: To the best of my know riedge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On Investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) THE POTHE P 0 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 21201 MID 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE SEP DHMH-15 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



| | | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPA CERTIF | RTMENT OF I | HEALTH AND | MENTAL HYGIEI | _ | |
|---|---------------|--|--|---|---|--------------------------------|---|------------------|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF OEATH |
| | | RICHARD J. BYR | NE Jr. | | | | | . 1994 | 01:22 A M |
| | | 4. SOCIAL SECURITY NUMBER | | (In yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 0.1 | BIRTHPLACE (State or Foreign Country) |
| 旦 | | 215-92-5376 | | 31 YRS. | MONTHS DATS | HOURS MIN. | 05/06/63 | 3 1 | Maryland |
| 3 should | æ | 9e. FACILITY NAME (If not institution, give si | | | 9b. CITY, TOWN | OR LOCATION OF D | DEATH | 9c. COUNTY | OF DEATH |
| 5,2,3 | DIRECTOR | ST.AGNES HOSPI' | ral | | BALT | IMORE | | | |
| sades | HH H | 10e. STATE 10b. COUNTY | | 10c. CI | TY, TOWN OR LOCA | TION | | | 10d, INSIDE CITY LIMITS? |
| # <u></u> | | MD | | В | altimore | | | | 1 X YES 2 NO |
| т реп | FUNERAL | 10e. STREET AND NUMBER | _ | | 10 | H. ZIP CODE | | | OF WHAT COUNTRY? |
| transi | N. | 1013 St. Charles | AVENUE 12. WAS DECEDENT EVER IN | NII C ADWED | | 21229 | | U.S. | |
| 21215-0020 al or attending physician. for use as the burial-transit permit, Pages | | 1 Never Merried 2 Merried | FORCES? 1 YES | 2 XNO | If yes, sp | pecify Cuben, Mexic | NIC ORIGIN? (Specify Yearn, Puerto Rican, atc.) | 14. | RACE — American Indian, Black, White, etc. |
| 215-0 attending | ВУ | 3 Widowed 4 Divorced | | | | S ZX NO Speci | ·y. | | specify: white |
| r attend | 밀 | 15. DECEDENT'S EDUC (Specify only highest grade | | (Give kind of | S USUAL OCCUPATI work done during me | ON ost of working | 16b. KIND OF BU | JSINESS/INDUST | RY |
| YLAND 21 by the hospital or be detached for u | COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT | 2 70 | nicion | Corrol | tox | |
| ANI the hos detache | NO I | 17. FATHER'S NAME (First, Middle, Last) | | Serv | ice Tech | - | COMPU | | |
| A to be a | | Richard J. Byrne | Sr. | | | | la Daughert | | |
| MARYLAND 2. retained by the hospital of should be detached for notified at once. |) BE | 19e. INFORMANT'S NAME (Type/Print) | | 196. MAILIN | G ADDRESS (Street | | Route Number, City or Tox | + | le) |
| BALTIMORE, MARYLAND ser death. Page 6 may be retained by the hospit the funeral director, page 5 should be detached val. Il examiner must be notified at once. | 욘 | Linda J. Byrne | | | | | timore, MI | | |
| ALTIMORE, I death. Page 6 may be funeral director, page examiner must be recovered. | | 20a, METHOD OF DISPOSITION 1 A Burlel 2 Cremetion 3 Remo | | PLACE AND DATE | OF DISPOSITION (No | eme of | OATE 20c. Le | DCATION — City | or Town, State |
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| ALTIN death, Pag tuneral dii l, examiner | | 21. SIGNATURE OF FUNERAL SERVICE LIG | The second secon | 1 | | | | | cal Home, Inc. |
| BAI after des by the fu moval. | | telo | 200 | 2 | 1 | | | | tus, MD 21227 |
| urs af in by rem | M | 23. PART I. Enter the diseases, or of ahock, or heart fellure. | omplications that caused List only one cause on a | d tha death. Do ach lina. | not enter tha mg | oda of dying, aud | ch as cardiac or reap | olratory arreat, | Approximate Interval Batween |
| filled on, or | - | IMMEDIATE CAUSE (Final disease or condition | | | | | | | Onset and Death |
| ted within completely fill ial, cremation; event, the | | resulting in death) | NARCOTIC AND | COCAINE I | | IN | | | |
| P 2 2 2 2 | _ | | DOE TO (ON AS A | CONSEQUENCE | <i>P</i> :): | | | | |
| | CERTIFICATION | Sequentially list conditions, If any, leading to immediate | OUE TO (OR AS A | CONSEQUENCE | OF): | | | | |
| P.O. BOX th certificate be a tending physician il Hygiene prior to or other traum | CA | cause. Entar UNDERLYING CAUSE (Disease or Injury | » | | | | | | |
| o.O.B. n certificate nding phys Hygiene p | | that initiated events resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE | OF): | | | | |
| eath certii attending mtal Hygies y, or oth | E | | | | | | | | |
| RDS, F at the death by the atter and Mental y Injury, o | | PART II. Other algnificant conditions | contributing to death b | out not reaulting | in the underlyin | g cauaa givan in | Part I. 24s. WAS AF | | 24b. WERE AUTOPSY FINDINGS |
| S that ned by with an | MEDICAL | | | | | | 1 YES | | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| RECO requires th been signed of Health shows an | ME | | | | | | _ ` | | 1 TES 2 NO |
| | Ž | DID TOBACCO USE CONTE | IBUTE TO CAUSE O | F DEATH Y | ES 🗌 NO 🗆 | UNCERTAI | Ν□ | | |
| ⊢ | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEA | TH (Check only one) | | | | |
| . D 5f | ₹ | 1 X YES 2 NO | 28e. DATE OF INJURY | ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Reelden | | | | | |
| NG PHYSIC inter this celeath with the | | 1 Natural 5 Pending | (Month, Day, Year) | FOUR | JURY WO | PRK? | 28d. OESCRIBE HOW | INJURY OCCURE | 0 |
| NDING NDING I: After r death | ВУ | 2 Accident Investigation 3 Suicide a XX Could not be | 280. PLACE OF INJURY | - At home, ferm, | DU A | | UNKNOWN 281. LOCATION (Street | end Number or B | ural Boute Number |
| S affe 85 | TED | 4 Homicide determined | building, etc. (Spec | e#y) UNKN(| | | City or Town, State |) | |
| DIV OR A DIREC hours | ш | 29e. CERTIFIER (Check only 1 CERTIFYING PHYSIC | CIAN: To the best of my know | | | end place, and due | | inner se stated | |
| THE HOSPITAL THE FUNERAL filed within 72 P | COMPL | | R: On the besis of examination | | | | | | use(e) end manner ee stated. |
| TO THE HOSPIT TO THE FUNERA De filed within 7 IMPORTANT: I | | 296. SIGNATURE AND TITLE OF CERTIFIER | 00 | 1 /2 = | | 29c. LICENSE NUI | | | SNED (Month, Day, Year) |
| 다 다 다 된 다 된 다 된 다 된 를 내 다 되 다 되 다 되 다 되 다 되 다 되 다 되 다 되 다 되 다 | S BE | KUMWPE | W XIL | 1 KM | | OCI | ME | | T.09,1994 |
| | 5 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | A CONTRACTOR | | | | | |
| | | MARGARITA KORE | WV | | nn Stre | eet, Ba | ltimore, | Maryl | and 21201 |
| U | | 31. DATE FILED (Month, Day Year) | 12 DECLARATE STATE | TORE | | | | | |
| | | - | 1 | | | | | | |



DHMH-18 Rev 1/89

| BALTIMORE, MARYLAND | after death. Page 6 may be retained by the hos | by the funeral director, page 5 should be detached semoval. | medical examiner must be notified at once. |
|--|---|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO THE HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the after death. Page 6 may be retained by the hos | TO THE FINISPAD DIRECTOR. After this certificate has been signed by the attending physician and complete not by the funeral director, page 5 should be detached the mitting. Hours after death with the State Deor, of Health and Mental Hyglene prior to burfal, crem | IMPORTANT: If July 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
| | _ | | _ |

| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTI | | | MENTAL HYGIEN | E | |
|---------------|--|---|--|---|-----------------------------|--|-------------------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | fle, Last) | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 214-35-3466 | 1 🗆 M 2 🗔 🗐 | 85 YRS. MC | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 08/07/07 | 8. Bi | RTHPLACE (State or Foreign unitry) |
| œ | 9e. FACILITY NAME (If not institution, give s | CAI - 1- IIII | .91 | | R LOCATION OF DE | ATH | 9c. COUNTY O | F DEATH |
| 5 | Caton Manor Nursi | | | | tmore | | | |
| DIRECTOR | | | | town on Location ltimore | | | 10d. INSIDE CITY LIMITS? 1 VES 2 NO | |
| RAL | 10e. STREET AND NUMBER 3330 Wilkens Avenue | | | 101. ZIP CODE 21229 | | | 10g. CITIZEN OF WHAT COUNTRY? | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Merried 3 X Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES | | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- If yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 VES 2 NO Specify: | | | | ACE — American Indien, lack, White, etc. pecity: White |
| ED | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 16a. DECEDENT'S US | UAL OCCUPATIO | ON et of working | 18b. KIND OF BU | SINESS/INDUSTR | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of work life. Do NOT use n Homemake | | 3. 3. V. 31. W. 19 | Self | | 10100 |
| OME | 17. FATHER'S NAME (First, Middle, Last) | | пошенак | EL. | 18. MOTHER'S NAI | ME (First, Middle, Maiden | Surneme) | |
| BE C | Louis Weisman | | | | Mae T | horpe | | |
| D B | 19e. INFORMANT'S NAME (Type/Print) | | | | | Noute Number, City or Tow | | |
| | Fred Klan 204 METHOD OF DISPOSITION | 200 | 4709 KI | | | icott City | CATION — City o | 21043 |
| | 1 Buriel 2 Cremation 3 Rem | oval from State | ake View I | | | | | e, Maryland |
| | 21. BIOMATPHE OF PUNETHAL SERVICENTA | | <u> </u> | 22. NAME AN | D ADDRESS OF FAC | Ambrose | F.H. (| of Lansdowne |
| | Haul V 4 | dan | | 2719 H | ammonds | Fry. Rd., | Lansdov | me, MD 21227 |
| | 23. PART I. Enter the diseases, or complectione that caused the death. Do not enter the mode of dying, such se cerdiec or respiratory arrest, shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) SQ VAROUS CELL CARCINOMA OF VULVA DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): AN EM I A | | | | | | | |
| MEDICAL | PART II. Other significent conditions contributing to death but not resulting in the underlying of the conditions contributing to death but not resulting in the underlying of the conditions contributing to death but not resulting in the underlying of the conditions of the condition | | | | g cause given in | Part i. 24a. WAS AN PERFOF | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PL | ACE OF DEATH (Che | ack only one) | | |
| SIC | EXAMINER? 1 VES 2 NO | HOSPITAL: 1 Inpetient 2 ER/Out | | THER: | e 5 🗆 Residence | e 🗆 Other (Specify) | | |
| ву рну | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Dey, Year) | 26b. TIME (| Y WO | URY AT RK? YES 2 NO | 2ed. DESCRIBE HOW I | NJURY OCCURE |) |
| ED | 3 Suicide 8 Could not be 4 Homicide Could not be determined 289. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 289. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | ral Route Number, | |
| OMPLET | 29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) end menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) and menner as stated. | | | | | | | |
| TO BE C | 29b. SIGNATURE AND TITLE OF CONTINE | Hazel " | 20 | | 29c. LICENSE NUN | BER | 29d. DATE SIGN | NEO (Month, Day, Year) |
| | 30. NAME AND ADDRESS OF PERSON WH | WARD | OBARE | | 21 N | · EUTA | w sī | BALTIMOR |
| | SFP 1 9 1994 | 32. REGISTRAR'S SIGN | ATURE | | | | | |

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rink printer

| BALTIMORE, MARYLAND 21215-0020 | nours after death. Page 6 may be retained by the hospital or attending physician. | n signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should Health and Mental Hygiene prior to burial, cremation, or removal. | medical examiner must be notified at once. |
|---|---|--|---|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | THE HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE PLACEMAL DIRECTORS ARE the sertificate has been signed by the attending physician and completely filled in by the fine within 72 hours are with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT II leng 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | | | | | | | | 94 | 26469 | |
|-----------|-------------|---|--|--|---|------------------|--------------------------------------|----------------|--|--|
| _ | _ | FOR 1 - STATE REGISTRAR | STATE OF MARYLAND / | DEPARTMEN ERTIFICAT | T OF HEALTH AND E OF DEATH | MENTA | L HYGIENE REG. NO. | | | |
| | | 1. DECEDENT'S NAME (First, Middle, Last) Wardell | | | lcher | 2. DATE | OF DEATH | 94 | 3. TIME OF OEATH 10:05 A M | |
| | | 4. SOCIAL SECURITY NUMBER 237-78-5969 | S. SEX 1 M 2 □ F H9 | r bettiday) IF UNDE VRS. MONTHS | R 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN. | | OF BIRTH | | BIRTHPLACE (State or Foreign Country) | |
| | 0 0 1 | maryland (| An Ancienty MAME (If not Institution, bire significant aumber) 10 10 10 10 10 10 10 10 10 10 10 10 10 1 | | | | | | | |
| | DIRECTOR | IDA STATE 196. COUNTY | 1 | 10c. CITY TOWN | OR LOGATION | , | J | | 10d. INSIDE CITY | |
| | - 10 | 10e. STREET AND NUMBER | Place | 12171 | 101. ZIP CODE | 17 | | 10g. CITIZEN | 1 YES 2 NO | |
| | FUNERAL | 11. MARITAL STATUS 1 Never Merried 2 Merried | 12. WAS DECEDENT EVER IN U.S. ARI FORCES? 1 YES 2 H | () (0 S | WAS DECENDENT OF HISPA. If yes, specify Cuben, Mexico | en, Puerto | N? (Specify Yee Ricen, etc.) | or No.— 14. | RACE — American Indian, Black, White, etc. | |
| | ED BY | 3 Widowed 4 Divorced 15. DECEOENT'S EQUE | | CEOENT'S USUAL (| | | . KIND OF BUS | INESS/INOUS | 500eth / ACK | |
| | COMPLET | (Specify only highest grade Elementery/Secondary (0-12) | | ive kind of work done Do NOT use retired.) | during most of working | | | | | |
| | BE CON | 17. FATHER'S NAME (First, Middle, Last) | Hunter | 4-31-12 | 18/MOTHER'S NA | ME (First, | Mide Maigr | Tob | 961. | |
| - 1 | TO B | 19a. INFORMANT'S NAME (Type/Print) | + Hunter | 2725 | (Signet and Number or Rural | Route Num | ALLE | State, Zio Co | 1/2 m/21211 | |
| | | 20s. METHOD OF DISPOSITION 14 Burial 2 Cremation 3 Plemo 4 Dispetion 5 Other (Specify) | ovel from State 295. PLACE A | AND DATE OF DISPO | Church C | m9/ | 2 Ed | ASTON - CHY | nhe N.C. | |
| | ı | 21. SIGNATURE OF FUNERAL SERVICE LIC | I Dun | / " | Seph 2 F | 208 | SFU | Jern | Home | |
| r | | 23. PART I. Enter the diseases, or c shock, or heart failure. | complications that caused the de List only one cause on each line | ath. Do not ente | r the mode of dying, suc | th as one | dias or respir | story srrest | interval Between | |
| 100 | | iMMEDIATE CAUSE (Final disease or condition resulting in deeth) | Arrhythmia | | | | | | Onset and Death 45 mins. | |
| | NO | Sequentially list conditions, | b. Myocardial DUE TO (OR AS A CONSECT DUE TO | Infar | ction | | | | 45 mins. | |
| | HIFICATION | if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | c. DUE TO (OR AS A CONSEC | , | | | | | | |
| * i i | CERT | resulting in death) LAST | d | | | | | | | |
| afen fina | MEDICAL | PART II. Other eignificent condition | e contributing to deeth but not re | esuiting In the u | nderlying cause given in | Part i. | 24a. WAS AN A PERFORM | MED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| | | DID TOBACCO USE C | CONTRIBUTE TO CAUS | SE OF DEA | TH YES 🗆 NO | | | | 1 - YES 2 NO | |
| | HYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | OTHE | 28. PLACE OF DEATH (CA | | ne) | | | |
| | Y S | 1 TYES 2 NO 27. MANNER OF DEATH | 1 Inpetient 2 XER/Outpetient 3 | | reing Home 5 Residence | _ | or (Specify) SCRIBE HOW IN | INDA OCCIN | En . | |
| | N | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJURY | WORK? | 200. DE | SCHIBE NOW IN | JOH! OCCOM | EU | |
| | | 3 Suicide 8 Could not be determined | 28e. PLACE OF INJURY — At hot building, etc. (Specify) | me, ferm, afreet, fed | tory, office | 28f. LOC City | CATION (Street er or Town, State) | nd Number or I | Rural Route Number, | |
| | PL | | CIAN: To the beat of my knowledge, de | | | | | | | |
| | COMPL | | R: On the beele of exemination and/or i | investigation, in my | | | e end place, end | | | |
| 1 | # | 29b. SIGNATURE AND TITLE OF CERTIFIER | bagat Al. | MD | 29c. LICENSE NUI 89192 | MBER | | 29d. DATE SI | SS (Wonth, Day, Year) | |
| | 2 ∦ | 30. NAME AND ADDRESS OF PERSON WHO | O COMPLETED CAUSE OF DEATH (ITEL | M 27) (Type Print) | | - | | // | - (/ 7 | |

296. SIGNATURE AND TITLE OF CERTIFIER Lagar AR. MD 296. LICENSE NUMBER 89192

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Liagat Ali, M.D. c/o Maryland General Hospital

31. DATE FILED (Morgin, Day, Year)

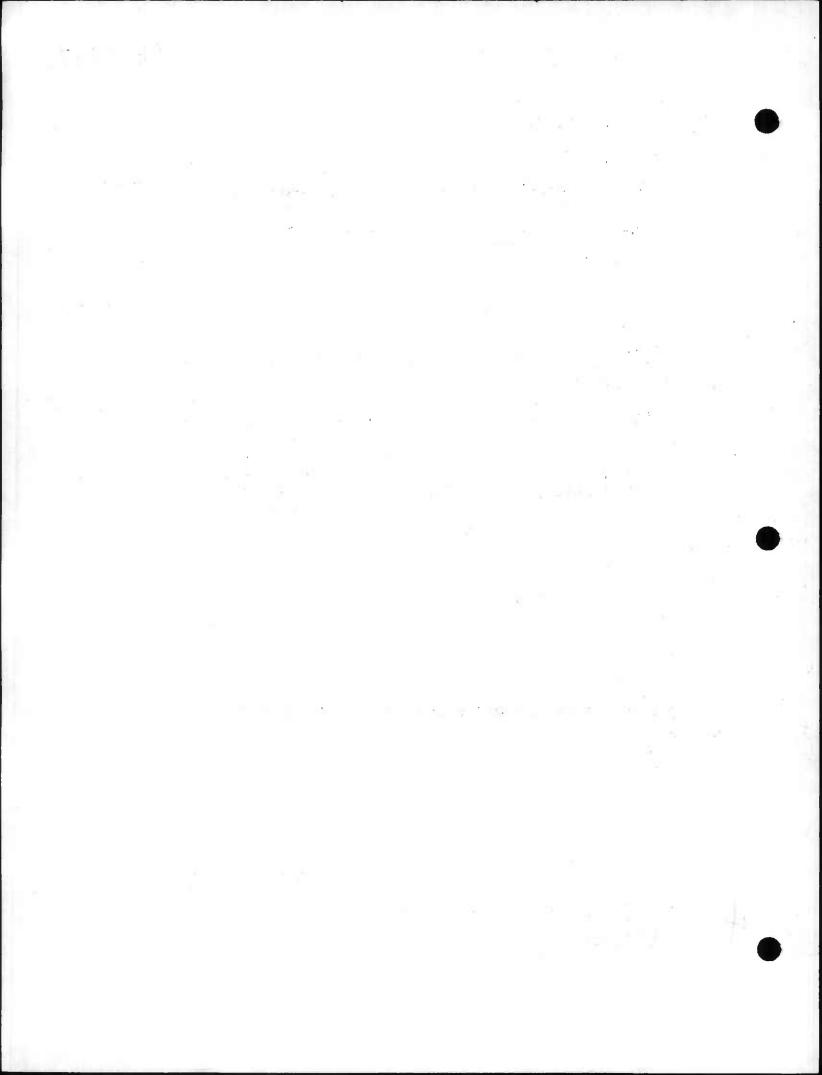
32. REGISTRAR'S GRATURE

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| OF V |
| VISION |
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| 1880007817 if the southerd on the south course once taken and the southern the sout |
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| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFIC | | | | YGIENE EG. NO. | | | |
|------------|---|---|---|-----------------|-------------------------|----------------|---------------------------|--------------|-----------------------------------|-------|
| | 1. DECEDENT'S NAME (First, Middle, La | , | | | | 2. DATE OF I | DEATN | | TIME OF DEATH | 1 |
| | Atheline C. | Bryant | | | | SEPT. | 9 19 | 94 | 5:30 | AM |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF B | HRTH 8 | BIRTHPL | ACE (State or For | eign |
| | 216-28-6925 | 1 🗆 M 2 🗆 F | 65 YRS. MO | NTHS DAYS | HOURS MIN. | (Month, De | | VIR | GINIA | |
| | 9s. FACILITY NAME (If not Institution, gi | | | CITY, TOWN C | R LOCATION OF D | EATH | 9c. COUNT | Y OF DEAT | | |
| CTOR | Union Memo | rial Hospit | al | Bal | timore | City | N | IONE | | |
| C | RESIDENCE OF DECEDENT 10e. STATE 10b. COU | | 10c, CITY, TO | OWN OR LOCAT | ION | | | 10 | d. INSIDE CITY | |
| DIRE | MARYLAND | NONE | | | FIMORE | CTTV | | | LIMITS? | 40 |
| | 10e. STREET AND NUMBER | | | | ZIP CODE | CIII | 10g. CITIZE | | T COUNTRY? | |
| ER | 5123 DARIEN | ROAD | | | 21206 | , | TINT | TED | STATE | S |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVER I | N U.S. ARMED | | ENDENT OF NISPA | NIC ORIGIN? (S | pecify Yes or No- 1 | RACE - | American India | |
| BY | 1 Never Merried 2 Merried 3 Widowed 4 Divorced | FORCES? 1 TYES | | | 2X NO Speci | | | Specify | /hite, stc. | |
| - 1 | | 1 | | <u> </u> | | | AHR | ICA | N AMER | ICA |
| ETED | 15. DECEDENT'S E (Specify only highest gr | DUCATION ade completed) | 18a. DECEDENT'S USI (Give kind of work | done during mo | N st of working | 16b. KIN | D OF BUSINESS/INDUS | STRY | | |
| ויי | Elementary/Secondary (0-12) | College (1-4 or 5 +) | life. Do NOT use re | , | | | | | | |
| COMPL | 9TH 17. FATNER'S NAME (First, Middle, Last) | NONE | НО | USEWI | | | ONE | | | |
| - 1 | JAMES MAYO | | | | | | e, Maiden Surname) | | | |
| BE | 19s. INFORMANT'S NAME (Type/Print) | | 105 MAIL ING AG | DOESS (Street - | | DIE | ity or Town, State, Zip C | - 4-1 | | |
| 2 | CARNELL MAYO | | | | IGTON R | | | BAL, | CO, MD | |
| | 20e. METHOD OF DISPOSITION | | . PLACE AND DATE OF D | | | OAD A. | 20c. LOCATION — CI | 212 | 229 | _ |
| | Q Buriel 2 ☐ Cremetion 3 ☐ R 4 ☐ Denstion 5 ☐ Other (Specify) _ | emoval from State | netery, cremetory or other ALTIMORE | place) | redv O. | 15 04 | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE) | HEITHORE | 22. NAME AN | D ADDRESS OF FA | CRITY | | | | AND |
| | > (c. V. 11 | Rixani | man V | | | | S FUNERA | | | |
| - 2 | Couver | D. XIVIUM | 10/ AL | 1412 | E. PRE | STON : | ST. BALT | O,MI | 212 | 13 |
| | 23. PART I. Enter the diseases, a ahock, or heart fellu | or complications that cause re. List only one cause on a | the death. Do not a | enter the mo | de of dying, aud | h ae cerdiec | or respiratory arres | it, | Approximatinterval Be | |
| | iMMEDIATE CAUSE (Finei diseese or condition | | | | | | | | Onset and | Death |
| J | resulting in death) | · SEF | | | | | | | 4 DI | 445 |
| 1 | | DUE TO (OR AS A | A CONSEQUENCE OF): | | | | | | | |
| 2 | Sequentially list conditions, | b. OUE TO (OR AS | A CONSEQUENCE OF: | | | | | | | |
| 4 | If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | |
| HILLAHON | CAUSE (Disease or Injury thet initiated events | C. OUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | |
| | resulting in death) LAST | d. | | | | | | | | |
| 3 | PADT II Other electrices and the | | | | IIIIn example (example) | | | | | |
| AL | PART II. Other eignificent condit | | | ne underlying | cause given in | Part I. 24a | WAS AN AUTOPSY PERFORMED? | AV | RE AUTOPSY FIN AILABLE PRIOR T | 0 |
| MEDIC | METASTATIC 184 | LEAST CANCEL | Z | | | 1 | YES 2 NO | | MPLETION OF CA DEATN? | NUSE |
| 2 | DID TODACCO HICE | CONTRIBUTE TO | C | | | | | 1 | YES 2 N | 0 |
| 2 | DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL | | CAUSE OF D | | | N/E | | | | |
| 2 | EXAMINER? | HOSPITAL: | | THER: | ACE OF DEATH (C) | | | | | |
| PHYSICIAN: | 27. MANNER OF DEATN | 1 Inpetient 2 ER/Out | 28b. TIME OF | | 5 Residence | | BE HOW INJURY OCCU | DEO | | |
| | 1 Natural 5 Pending | (Month, Day, Year) | INJURY | WO | RK? | 280. VEŞCHIE | SE HOW INJURY OCCU | HEO | | |
| à | 2 Accident Investigation 3 Suicide & Could not | 28s. PLACE OF INJURY | / — At home, ferm, stree | | | 284 LOCATIO | N (Street and Number or | Pural Boud | n Mumber | |
| 3 | 4 Homicide 6 Could not determined | building, stc. (Spe | cify) | ,, | | City or To | | rioral Floor | o Humber, | |
| | 29s. CERTIFIER | WA101411 - 11 - 11 - 11 - 11 - 11 - 11 - 1 | | 4910 00 | | | Les controls Survey | | | |
| COMPLE | 000) | YSICIAN: To the best of my know | | | | | | | | |
| 3 | | INER: On the besis of exemination | ni sild/or investigation, ii | і ту ориноп, а | | | | | | rted. |
| | 296. SIGNATURE AND TITLE OF CERTI | | | | 29c. LICENSE NU | MBER | 29d, DATE S | SIGNED (M | onth, Day, Year) | |
| 2 | 30. NAME AND AODRESS OF PERSON | MNO COMPLETES SAUSE ST | - INTERN | -1 | -Alg | 4301 | 76 7 | 1919 | 7 | |
| | ARVINAR BA | | F MEDICL | | Al 1 - A44 | . 4400 : | 11000 " | 7.4. | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGN | | 17 0 | INIUN INIS | MURIA | e Hosp., 7 | SHUT! | MORE, | M |
| Ì | SEP 1 2 1994 | | | | | | | | | |



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

| Nours after death. Page 6 may be retained by the hospital or attending physician. | O THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funerial director, page 5 should be detached for use as the burial-transit perm | tion, or removal. | the madical avaminar must be entitled at secon |
|---|---|-------------------|--|
| ed within | completel | al, crema | event |
| e execut | an and o | r to buri | umatic |
| ificate b | physici | ene prio | her tra |
| ath cert | tending | al Hygie | or of |
| the de | the at | d Ment | Inline |
| s that | ned by | lith an | AUN |
| require | een sig | of He | shows |
| e aw | has b | Dept. | 23 |
| 2 | ficate | State | Hen |
| VSICI) | s cert | th the | o pa |
| E PH | ter thi | ath w | marke |
| ENDIN | JR: Af | ter de | 2 8 |
| RAIT | RECT | urs af | 20 |
| AL O | AL DI | 72 ho | If He |
| OSPI | UNER. | uthin | ANT |
| O THE H | 9 THE F | e filed w | MPORT |
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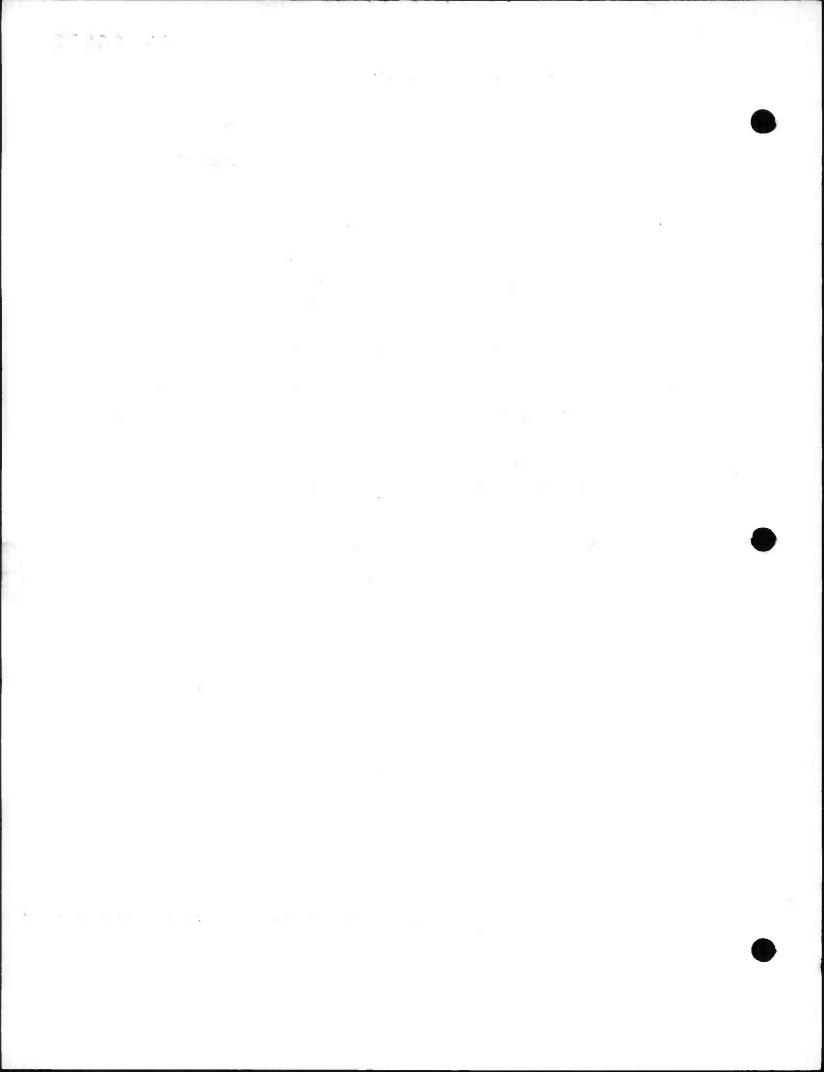
| | ASP | | | | | | | 9 | 4 2 | 64/1 | |
|-----------------------|---|---|---|--------------------|---|---------------------------------|---|--------------------------|---|--|--|
| | 1 - FOR STATE REGISTRAR | STATE OF MAR | | | | EALTH AND I | MENTAL HYGIEN | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) TIMOTHY CARSON | J | | | | | 2. DATE OF DEATH MONTH 09 | ^ 1994 | MEAN | 9:16 P M | |
| | | 6. A | GE (In yrs. last birtnday) 25 YRS. | IF UNDER MONTHS | 1 YEAR DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 4/5/196 | 9 | 6. BIRTHPL Country) BALT | ACE (State or Foreign | |
| OR | 9s. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE MARYLAND 10b. COUNTY | 10a. STATE 10b. COUNTY 10c. C | | | | ETY, TOWN OR LOCATION BALTIMORE | | | 10d. INSIDE CI LIMITS? 1 (X YES 2 | | |
| | 10. STREET AND NUMBER | | | | 101. | . ZIP CODE | | 10g. CITIZEN OF WHAT COU | | | |
| BY FUNERAL | 5117 PEMBRIDGE 11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced | AVENUE 2. WAS DECEDENT EVENUE FORCES? 1 Y IF YES, GIVE WAR O | | - 11 | yea, spe | | IIC ORIGIN? (Specify Yes | or No— | 14. RACE - Black, 1 Specify: | - American Indien, White, etc. | |
| COMPLETED E | 15. DECEDENT'S EDUCATION (Specify only highest grade con Elementary/Secondary (0-12) | FION mpleted) College (1-4 or 5+) | 16e. DECEDENT'S (Give kind of life. Do NOT to | work done d | CUPATIO | N st of working | Dunca | | | Black | |
| | 17. FATHER'S NAME (First, Middle, Last) Robert Carson | | | | | 16. MOTHER'S NAME Mable | ME (First, Middle, Malden Smith | Surname) | _ | | |
| TO BE | 19a, INFORMANT'S NAME (Type/Print) Mable Smith | | | | | | Route Number, City or Tow | | | 21215 | |
| | 20e. METHOD OF DISPOSITION 1 Description 1 Company 2 Cremetton 3 Remove 4 Donation 5 Other (Specify) | If from State | 20b. PLACE AND DATE cometery, crematory or St. Luke | s (J | .M. | Church | O OATE 20c. LO | nkt | on, N | Maryland | |
| | 21. SIGNATURE/OF FUNERAL SERVICE LICEN | | utt | | | | ETT & SON | | | | |
| | 23. PART Letter the disease, or conshock, or heart failule. Lis IMMEDIATE CAUSE (Final disease or condition recuiting in deeth) | t only one ceuse o | the deeth. Do neach line. | | tha mod | de of dying, sucl | h es cardiac or reepi | iratory an | reet, | Approximate Interval Between Onset and Death | |
| ERTIFICATION | Sequentially liet conditione, if arry, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR A | AS A CONSEQUENCE C | DF): | | | | | | | |
| PHYSICIAN: MEDICAL CE | PERFORMED? 1 VYES 2 NO OF DEATH? | | | | | | | | ERE AUTOPSY FINDINGS MILABLE PRIOR TO DMPLETION OF CAUSE F DEATH? U YES 2 NO | | |
| CIAN: N | DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | OF DEATH Y | TH (Check o | nly one) | UNCERTAIN | N 🗆 | | | (grica 2 NO | |
| | 1X YES 2 NO 1 Impatient 2 ER/Outpetient 3X DOA 4 Nursing Home 5 27. MANNER OF-DEATH 1 Matural 5 Pending 28e. OATE OF thJURY (Month, Dey, Year) 28b. TIME OF INJURY MORK? | | | | | JRY AT | 6 Other (Specify) 28d. DESCRIBE HOW II | NJURY OC | CUREO | | |
| ETED BY | 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJ building, atc. (5 | URY — At home, farm, Specify) | street, facto | ery, office | | 281. LOCATION (Street a City or Town, State) | | or Rural Rou | te Number, | |
| COMPLET | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAL EXAMINER: C | | | | | | to the cause(a) and mar time, data and place, an | | | nd manner as stated. | |
| BE | 29b. SIGNATURE THO TITLE OF CERTIFIER | 2 Char | 4 mg | | | O.C.M. | | | | onth, Day, Year) | |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO | OMPLETED CAUSE OF | DEATH (ITEM 27) (7/D) | Print) | | | | | | | |

DEATH (ITEM 27) (Type, Print)
111 Penn Street, Baltimore, Maryland 21201

March of the first the last

Item # 6,70Film # 6 715 09-12-94 N OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH SEPT COLEMAN 06 6:08 P .M DORIS 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 45 47 DAYS HOURS 248-86-5690 Country 1 🗌 M 2 🔀 F ours after death. Page 6 may be retained by the hospital or attending physician. I in by the funeral director, page 5 should be detached for use as the burla-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH RECTOR 2127 N.SMALLWOOD STREET BALTIMORE CITY RESIDENCE OF DECEDENT 10e. STATE 10b, COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD YES 2 NO BALTO ā 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 2127 SMALLWOOD 21216 ST. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2. 710 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indien, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Naver Married 2 XMerriad FORCES? 1 YES 22
IF YES, GIVE WAR OR OATES 8 1 TES XXNO Specify: Specify: 3 Widowed 4 Divorced BLACK ED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) (Specify only highest grade П Elementary/Secondary (0-12) College (1-4 or 5+) UNKNOWN COMPL 12TH once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) GRACE Ħ OWEN GORIE ANNIE YOUNG notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street LING ADDRESS (Street and Number or Rural

1, BOX 382-B P A S.C. 29126 POMARIA 2 ANNIE GORIE HELLER RT20e. METHOD OF DISPOSITION
2 Cremetion 3 Removal from State pe 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - Cify or Town, State must XIXBuriel 2 Crametion 3 Ramoval fro
4 Donation 5 Other (Specify)
21. SIGNATURE OF FUNERAL SERVICE LIFENSEE KING MEMORIAL PK 91294 RANDALLSTOWN, MD examiner 22. NAME AND ADDRESS OF FACILITY MARCH F/H-WEST 4300 WABASH AVE ume attending physician and completely filled in by the intra Hygiene prior to burtal, cremation, or removal. medical 23. PART/. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. Intarvai Batween 0 IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition HYPERTEUSIVE CARDIOVASCULAR DISEASE & resulting in death) event, DIVISION OF VITAL RECORDS, P.O. BOX 68760, executed with PISORDER SEIZUKE traumatic CERTIFICATION Sequentially list conditions. DUE TO YOR AS A CONSEQUENCE OF if any, leading to immediate death certificate be cause. Entar UNDERLYING CAUSE (Disease or injury other Mental Hygiene OUE TO (OR AS A CONSEQUENCE OF). that initieted events resulting in death) LAST 0 injury, Health and Men PART ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF ATTENDING PHYSICIAN: The law requires that the MEDICAL shows any 1 YES 2 NO OF OFATH? 1 YES 2 NO certificate has been h the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) item HOSPITAL: OTHER: 1 XYES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Home XXRasidence 8 ☐ Other (Specify) the 6 27. MANNER OF DEATH 28a. DATE OF INJURY with t 28b. TIME OF 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28 is marked, INJURY 1 Natural M 1 YES 2 NO 8 After _ Accident Investigation 26e. PLACE OF INJURY — At home, term, street, tectory, office 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suictde 6 Could not be COMPLETED DIRECTOR after 4 Homicide Nours Hell 29e, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(e) and menner ee stated. ANTAB 걸 on end/or investigation, in my opinion, death occured at the time, data end placa, end due to the cause(s) end menner as stated. GRATURE AND TITLE OF CERTIFIE 29st. DATE SIGNED (Month, Dwy. Year) BE SEPT 7,1994 C.M.E. 2 00, HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (1)596, PTITLE (00) Penn Street, Baltimore, Maryland 21201 32. REGISTRAS S. SKY ATAN SEY 12 1334



| 1 | - | STATE REGISTRAR |
|---|---|--------------------|
| - | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CERTIF | ICATE OF | DEATH | REG. NO | | | |
|---------------|--|----------------------------|---|---------------------------------------|--|--|------------------|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Charles Edwa | ard Car | ey Jr. | | | 2. DATE OF DEATH Sept. 10, | | 3. TIME OF DEATH | |
| | 218-26-7070 | Š M 2 □ F | 6. AGE (In yrs. last birthday) 63 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Jul.12,1 | 931 Ma | IRTHPLACE (State or Foreign country) | |
| TOR | 98. FACILITY NAME (If not institution, give street and number) 413 Annette Ave. Stevensville PLEASIDENCE OF DECEDENT 99. CITY, TOWN OR LOCATION OF DEATH Stevensville Queen Annes | | | | | | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY | Annes | | ry, town on Loca Vensvi | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 KNO | |
| FUNERAL | 10e. STREET AND NUMBER | | | 10 | f. ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? | |
| N. | 413 Annette Ave. | **** | | | 21666 | | USA | | |
| B≺ | 1 Never Married 2 - Married | | EVER IN U.S. ARMED XYES 2 NO R OR DATES 55 | If yes, sp | CENDENT OF HISPAN Secify Cuban, Mexice 3 2 XNO Specify | IIC ORIGIN? (Specify Yes n, Puerto Rican, stc.) | | RACE American Indien, Black, White, etc. Specify: White | |
| 邑 | 15. DECEOENT'S EDUCATION (Specify only highest grade company) | | 18e. DECEDENT'S | USUAL OCCUPATI work done during me | ON ost of working | 16b. KIND OF BUS | SINESS/INDUSTR | Y | |
| COMPLETED | Elementary/Secondary (0-12) Co | ollege (1-4 or 5+) | Truck | se retired.) | | Trı | ıcking | | |
| BE CO | 17. FATHER'S NAME (First, Middle, Last) Charles Edward C | arey S | r. | | | ME (First, Middle, Malden nna Heler | | ht | |
| TO 5 | Marie F. carey | | 19 <u>5. MAY</u> IN | Annette | and Number or Rural & Ave. | Stevensv: | ILLE, | MD 21666 | |
| | 20e. METHOD OF DISPOSITION 1 (X \$\delta_0^2\text{rie} rie 2 \cap \text{Cremation 3 \cap Ramoval} \text{4 \cap Donation 5 \cap \text{Other} (Specify)} | from State | 206. PLACE AND DATE COMPLETY, CREMETON OF ALL | of disposition (Nother place) OWS Epi | isc. Ch | OATE 20c. LO | CATION — City of | nvilleMD | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENS Thomas | Hayle | otes | 22. NAME A Haro | nd address of fa desty Fi | uneral Ho | ome, P | | |
| NOI | 23. PART I. Enter the diseases, or companock, or heart fellure. List IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if sny, leading to immediate | only ona cause | on aach lina. | Hepat | | n as cardiac or reapi | ratory srrest, | Approximata interval Between Onsat and Death SMOS. | |
| CERTIFICATION | csuse. Enter UNDERLYING CAUSE (Disease or Injury that Initiated avents resulting in death) LAST d. | | OR AS A CONSEQUENCE O | | | | | | |
| MEDICAL | PART II. Other significant conditions co | Alcoho | l misus | 2 | | PERFOR | MED? | 24b, WERE AUTOPSY FINDINGS AMAILABLE PRIDE TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| PHYSICIAN: | DID TOBACCO USE CONTRIBUTION WAS CASE REFERRED TO MEDICAL | UTE TO CAU | | | UNCERTAIN | 1 25 | | | |
| Si Ci | EXAMINER? | OSPITAL: | 26. PLACE OF DEA | TH (Check only one) OTHER: | .>/ | | | | |
| Ě | 27. MANNER OF DEATH | 28a, OATE OF IN | JURY 28h TIB | E OF 28c. IN. | NO 5 Residence | 28d. OE\$CRIBE HOW II | NJURY OCCURE | | |
| BY P | Natural 5 Pending 2 Accident Investigation | (Month, Day, | 7007) IN | M 1 D | YES 2 NO | | | | |
| | 3 Suicide 8 Could not be 4 Homicide datermined | 28a. PLACE OF building, st | INJURY — At home, farm, c. (Specify) | atrast, factory, offic | • | 28f. LOCATION (Street a City or Town, State) | and Number or Ru | ral Route Number, | |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN 2 MEDICAL EXAMINER: Or | | | | | | | se(s) and menner as stated. | |
| BE | 296 SIGNATURE AND TITLE OF CERTIFIER | oull | Luo | | 29c. LICENSE NUN | | | NEO (Month, Day, Year) | |
| 7 | 30, NAME AND ADDRESS OF PERSON WHO CO STUART E. Seloui | MPLETED CAUSE | OF DEATH (ITEM 27) (Type OO Best oo | Prim) He Rd | . Au | rapolis, V | ud. | 21401 | |
| | 31. DATE FUEO (Month, Day Your) 5EP 1 2 1994 4 | 32 REGISTRAR | S SIGNATURE | | | - | | | |

TO THE HOBPITAL OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOBPITAL OF ATTIVIONS PHYSICIAN: The law requires that the death cartificate be executed within an observation of the property lifed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 mons after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-18 Rev 1/89

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| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | NATE OF STREET, OF STREET, The last condens that the death considers by second sidely |
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| 0 | 0 |
| | DATE: |

30. NAME AND ADDRESS OF

31. DATE FILED (Month, Day, Year)
SEP 12 1994

LOCUST

| | 1. DECEDENT'S NAME (First, Middle, Last | 0 | CERTIFICAT | O DEATH | REG. NO. | 3. TIME OF DEATH |
|---------------------------------|--|--|--|--|---|--|
| 3.0 | LAWRENCE | J CA | RBERRI | -[| WONTH DAY | 74 6:00 |
| | 4. SOCIAL SECURITY NUMBER | / | MONTH | DER 1 YEAR IF UNDER 24 HRS. B DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Fore Country) |
| | As. FACILITY NAME (If not institution, give | 1 DM 2 DF | 75 YAS. | ITY, TOWN OR LOCATION OF | 112/2/18 | DASH D. C |
| CTOR | PROJEW HAVOR | Extended CA | effectie C | CLINTON, N | ID Pen | r E Goodge |
| DIREC | 10a. STATE 10b. COUNTY | CE GOOLAF | 10c, CITY, TOWN | ASH (NGTO | N | 10d. INSIDE CITY LIMITS? 1 YES 2 1 |
| 3AL | 10e. STREET AND NUMBER | 105 1 | | 101. ZIP CODE | 10g. CITIZ | ZEN OF WHAT COUNTRY? |
| FUNERAL | 1303 PENME | AUE AUEA | JUE | 20744 | 4 | .S. A. |
| BY FU | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 YES | 2 200 | 3. WAS DECENDENT OF NISP/ If yes, specify Cuben, Mexic 1 YES 2 NO Specify | en, Puerto Rican, atc.) | 14. RACE — American Indies Black, White, atc. Specify: |
| ED | 15. DECEDENT'S ED (Specify only highest gra- | OUCATION de completed | 18e. DECEDENT'S USUAL | OCCUPATION ne during most of working | 16b. KIND OF BUSINESS/INDI | USTRY |
| LET | Elementary/Secondary (0-12) | Coflege (1-4 or 5+) | life. Do NOT use retired | 1.) | Cilham == | |
| COMPL | 77. FATHER'S NAME (First, Middle, Last) | | security | Guard | Gilbert Se | curity Co. |
| _ | Charlie | Cark | 20114 | | AME (First, Middle, Melden Surname) 1 bell Shef | 20. 1 |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | | | 1 Bell Shef 1 Route Number, City or Town, State, Zip | |
| 5 | Lawrence H. | Carberry | | | Ave Fort wasi | |
| | 20a. METHOD OF DISPOSITION 1 M Buriel 2 Cremetion 3 Re | | b. PLACE AND DATE OF DISP | OSITION (Name of | OATE 20c. LOCATION - C | |
| | 4 Donation 8 Other (Specify) | P | metery, crematory or other plea easant valle | y Mem PK | | dale, vq. |
| 1 | 21. SIGNATURE OF FUNERAL SERVICE I | LICENSEE | 2 | Z. NAME AND ADDRESS OF F | ACILITY | - |
| | | 0 1 10 | | Claired E | LARVAL SEYVI | C.e. |
| | * Robert & | Balang | 4 | ChiNN FO | ineval servi | ce d. avl. vg. |
| | 23. PART I. Enter the diseasea, or shock, or heart fellure | r complications that cause | d the deeth. Do not ent | ChiNN FO | ineval servi | eet, Approxima |
| | ahock, or heart fellure IMMEDIATE CAUSE (Final | r complications that cause s. List only one cause on | d the deeth. Do not ent | ChiNN FO | ineval servi | eet, Approxima |
| | ahock, or heart fellure | a. Resh | ed the deeth. Do not ent | ChiNN FO | ineval servi | eet, Approxima |
| | ahock, or heart fellure IMMEDIATE CAUSE (Final disease or condition | a. Resh | d the deeth. Do not ent | ChiNN FO | ineval servi | eet, Approxima |
| NOI | ahock, or heart fellure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, | a. Resh | and the deeth. Do not entered line. | ChiNN FO | ineval servi | eet, Approxima |
| CATION | ahock, or heart fellure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | a. Rust poly one ceuse on Due to on As | ed the deeth. Do not ent | ChiNN FO | ineval servi | eet, Approximation interval Be |
| TIFICATION | ahock, or heart fellure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | a. Due to on as | and the deeth. Do not entered line. | ChiNN FO | ineval servi | eet, Approximation interval Be |
| RTIF | ahock, or heart fellure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditiona, If arry, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | a. Due to on as | a CONSEQUENCE OF: | ChiNN FO | ineval servi | eet, Approxima |
| L CERTIFI | ahock, or heart fellure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | DUE TO OR AS C. OUE TO OR AS OUE TO OR AS | A CONSEQUENCE OF): | ChiNN FOR 26 05 Jo. S. S. S. S. S. S. S. S. S. S. S. S. S. | the real Seyving to Recharge of respiratory arrespiratory | A, QYI-V9, Deet, Approximatinterval Be Onset and ADD Mash |
| L CERTIFI | ahock, or heart fellure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditiona, if amy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that inlittated events resulting in death) LAST | DUE TO OR AS C. OUE TO OR AS OUE TO OR AS | A CONSEQUENCE OF): | ChiNN FOR 26 05 Jo. S. S. S. S. S. S. S. S. S. S. S. S. S. | neval Seyvi hivington R chee cerdiec of reepiretory arre | Approximatinterval Be Onset and Onset and Onset and Onset Approximation of Comparison |
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| AN: MEDICAL CERTIFI | ahock, or heart fellure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditiona, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent condition EXAMINER? | DUE TO OR AS C. OUE TO OR AS OUE TO OR AS | A CONSEQUENCE OF): A CONSEQUENCE OF): but not resulting in the | ChiNN FOR 26 05 Jo. S. 1 | In Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 Part I. YES 2 NO | Approximatinterval Be Onset and Onse |
| YSICIAN: MEDICAL CERTIFI | ahock, or heart fellure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditiona, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | DUE TO OR AS C. DUE TO OR AS DUE TO OR AS DUE TO OR AS DUE TO OR AS DUE TO OR AS DUE TO OR AS DUE TO OR AS DUE TO OR AS DUE TO OR AS | a CONSEQUENCE OF): but not resulting in the state of the consequence | ChiNN FOR 26 05 Jo. Silver the mode of dying, surer the mode of dying, | Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | 24b. WERE AUTOPSY FINANJABLE PRIOR TO COMPLETION OF CUDE OBJECTION OBJECTI |
| PHYSICIAN: MEDICAL CERTIFI | ahock, or heart fellure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditiona, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent condition EXAMINER? | DUE TO OR AS C. DUE TO OR AS d. DONE CONTRIBUTING TO GENTAL HOSPITAL: | a CONSEQUENCE OF): but not resulting in the | ChiNN For 26 05 Jo. Silver the mode of dying, su fer the mode of dying | neval Seyvi hiviington R ch se cerdiec or reepiretory arre | 24b. WERE AUTOPSY FINANJABLE PRIOR TO COMPLETION OF CUDE OBJECTION OBJECTI |
| BY PHYSICIAN: MEDICAL CERTIFI | ahock, or heart fellure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditiona, If arry, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigation | DUE TO OR AS DUE TO OR AS C. DUE TO OR AS d. DOE TO OR AS HOSPITAL: | A CONSEQUENCE OF): A CONSEQUENCE OF): Double of the deeth, Do not enterest of the deeth, Do not enterest of the deeth of | ChiNN For 26 OS Jo. S. S. S. S. S. S. S. S. S. S. S. S. S. | Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 2 Bd. DESCRIBE HOW INJURY OCC | 24b. WERE AUTOPSY FIN AMAILABLE PRIOR T COMPLETION OF CA |
| D BY PHYSICIAN: MEDICAL CERTIFI | ahock, or heart fellure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditiona, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH Netural 5 Pending | DUE TO OR AS DUE TO OR AS C. DUE TO OR AS d. DOE TO OR AS HOSPITAL: | A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF): but not resulting in the consequence of the cons | ChiNN For 26 OS Jo. S. S. S. S. S. S. S. S. S. S. S. S. S. | Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | 24b. WERE AUTOPSY FINANALABLE PRIOR 1 OF OCCUPANT 1 YES 2 N |
| BY PHYSICIAN: MEDICAL CERTIFI | ahock, or heart fellure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent conditions in the condition of the cond | DUE TO OR AS | A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF): Dut not resulting in the consequence of injury M | chinn For 26 of Jon Store the mode of dying, su fer the mode of dying, | Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 2 No No No No No No No N | 24b. WERE AUTOPSY FINANALABLE PRIOR COMPLETION OF CORP. |

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| | | 1 - STATE OF MARYLAN | ID / DEPARTMENT OF HEALTH AI CERTIFICATE OF DEATH | | |
|--|---------------|--|---|---|---|
| | 2000 | 1. DECEDENT'S NAME (First, Middle, Last) JAMES D. DIXON | | 2. DATE OF DEATH MONTH DAY | 1904 5 50 PM |
| D | | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in) $2 \cdot 19 - 50 - 353/$ 1 150 M $2 \cdot 15$ 4 | //S. last birthday) IF UNDER 1 YEAR IF UNDER 24 YRS. MONTHS DAYS HOURS R | | B. BIRTHPLACE (State or Foreign Country) H. C. |
| 2, 3 should | TOR | 96. FACILITY NAME (If not institution, give street and number) St Agnes Hospi Full RESIDENCE OF DECEDENT | 96. CHY, TOWN OR LOCATION PALTIMORE | | COUNTY OF DEATH |
| permit, Pages 1, | DIRECTOR | 10e. STATE 10b. COUNTY | 10c. CITY, TOWN OR LOCATION Balto | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| n. ansit permi | FUNERAL | 302 Allendale St | 101. ZIP CODE 2/2 | .29 log. | CITIZEN OF WHAT COUNTRY? |
| 15-0020 ending physician. as the burial-transit | BY | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE | 2 NO If yee, specify Cuben, I | HISPANIC ORIGIN? (Specify Yee or No Mexicen, Puerto Ricen, etc.) Specify: | - 14. RACE - American Indien, Black, White, etc. Specify: Black |
| 212 | PLETED | 15. OECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | Se. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Un Known | 16b. KIND OF BUSINESS | C/INDUSTRY |
| YLAND 1 by the hospit d be detached d at once. | E COMPL | 17. FATHER'S NAME (First, Middle Leat) | | R'S NAME (First, Middle, Melden Surnan | ne) |
| E, MAR, y be retained bage 5 should be notified | TO B | Alexander Dixon | 19b. MAILING ADDRESS (Street end Number or 2. Hobart Ct | Rural Boute Number, City or Town/State Kandallstou | 1. 11/1 |
| ALTIMORE, death. Page 6 may be funeral director, page axaminer must be | | 1 D Burlel 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) | ACE AND DATE OF DISPOSITION (Name of Parametery or offer place). | M 9/13/94 Bai | N — City or Town, State |
| BALTIMOF ter death. Page 6 m the funeral director, vval. | | 21. SIGNATURE OF PUNERAL SERVICE LICENSEE B- | 22. NAME AND ADDRESS. | of FACILITY Wast | Ave |
| nours after the filled in by mation, or remot, the medical | | 23. PART I Enter the dispose, or complications that caused the ahock, or heart failure. List only one cause on each IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A C | h lina. | | Approximate Interval Between Onset and Death |
| BOX 68. ficate be execute physician and c ne prior to buna ner traumatic | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | ONSEQUENCE OF): ONSEQUENCE OF): | lure | 9 day, 4 monte |
| DS, Interest the attental of Mental injury, | AL CE | PART II. Other significant conditions contributing to death but | not resulting in the underlying cause give | en In Part I. 24a. WAS AN AUTOF PERFORMED? | |
| CO signed Health | MEDIC | | | 1 VES 2 NO | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| law as been 23 | SICIAN: | DID TOBACCO USE CONTRIBUTE TO (25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO No Inpetient 2 ER/Outpetle | 26. PLACE OF DEAT | | |
| OF PHYSICI this cer with th | у РНУ | 27. MANNER OF DEATH 1 Netural 5 Pending (Month, Day, Yeer) 2 Accident | ant 3 DOA 4 Nursing Home 5 Resider 28b. TIME OF NUTURY AT WORK? 1 YES 2 N | 28d. DESCRIBE HOW INJURY | OCCURED |
| DIVISION DIFFERENCE Path New Control of the | enteo B | A DECIDENT | At home, ferm, street, factory, office | 26f. LOCATION (Street end Nui City or Town, State) | mber or Rural Route Number, |
| E 845 | COMPE | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowled one) 2 MEDICAL EXAMINER: On the best of examination e | | | |
| TO THE HOS TO THE FUN De Ned with IMPORTAN | O BE C | 296. SIGNATURE AND TITLE OF CERTIFIER RESIDENT | | | DATE SIGNED (Month, Day, Year) 09/09/94 |
|) | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH | (ITEM 27) (Type, Print) | 3 | |

31. DATE FILED (Month, Day, Year)

09/09 85 P. 1 2 1994

Juniorian Russes

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within so hours after death. Page 6 may be retained by the hospital or attending physician.

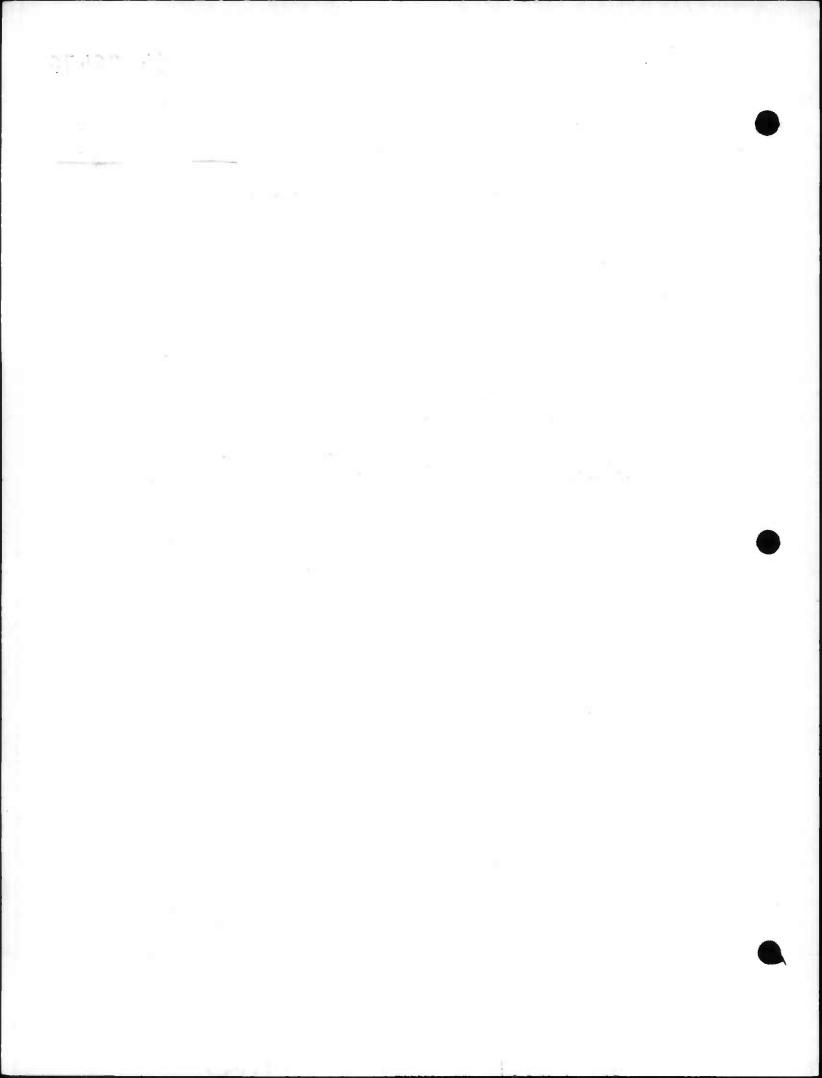
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE OF MARYLANI REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| _ | | | | | | HEG. NC | | | | |
|------------|--|-----------------|---|--------------------|------------------------|---------------------------|---------------------|---|--|--|
| i | 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH | | | | SEAR 3. TIME OF DEATH | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE | (In yrs. last b | irthday) IF L | MDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 0 - 1 | MINTHPLACE (State or Foreign | | |
| ļ | 181-28-30 40 1 M 2 F | YRS. MON | RS. MONTHS DAYS HOURS MIN. (Month, Day, that) | | | | Maryland | | | |
| E | FALLSTON GENERAL | HUS | | F | A1/CT | - CA | 11 | ARFORD | | |
| DIRECTOR | RESIDENCE OF DECEDENT | | | | 11001 | 07 | 1 // | ARFORD | | |
| | 10e. STATE 10b. COUNTY | | 10c. CITY, TO | WN OR LOC | | | | 10d. INSIDE CITY LIMITS? | | |
| | Maryland Harford | | | | White | Hall | | 1 TYES 2 X NO | | |
| FUNERAL | 4345-B Norrisville Road | | | - | of. ZIP CODE | () | 10g. CITIZ | EN OF WHAT COUNTRY? | | |
| | 11. MARITAL STATUS 12. WAS DECEDENT EVER | IN II S ADM | in I | 12 Wh C OF | 211 | HC ORIGIN? (Specify Ye | No. 1 | USA 14. RACE — American Indian. | | |
| | 1 Never Merried 2 Merried FORCES? 1 YES | 2 XNO | | If yes, s | | n, Puerto Rican, etc.) | a or No | Black, White, atc. | | |
| B | 3 Wildowed 4 Divorced | DATES | | 1 12 | S Z X NO Specin | <i>y.</i> | | White | | |
| | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | (Give | DENT'S USU | done durina n | ION lost of working | 16b. KIND OF BU | SINESS/INDU | JSTRY | | |
| ۳ | Elementary/Secondary (0-12) College (1-4 or 5 +) | | o NOT use reti | | | | | | | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | main | tenano | ce wo | | ME (First, Middle, Melder | | Co. Schools | | |
| - 1 | " Unavailable | . " | | | IO. MOTHER S NA | " Unavai | | , II | | |
| O BE | 19e. INFORMANT'S NAME (Type/Print) | | MAILING ADD | RESS (Street | end Number or Rural I | Route Number, City or Tox | | | | |
| ĭ | Joan A. Witkowski | 43 | 45-B | Norr | isville | Rd. Wh | ite H | Hall,MD 21161 | | |
| | 20e. METHOD OF DISPOSITION 1 Burlei 2 Cremetion 3 Removal from State | b. PLACE AN | D DATE OF DI | SPOSITION (F | y,Inc. | DATE 20c 10 | CATION — C | City or Town, State | | |
| | 4 Donation 8 Other (Specify) 21. SIGNATURE OF TRERAL SERVICE LICEUSEE | etro | Crei | 22. NAME | Y, Inc. | 9/12 B | /12 Baltimore, MD | | | |
| | Cooper E Wallet | | | Crem | ation S | ociety o | f Md. | ., Inc. | | |
| | George E. MacNabb 23. PART I. Enter the diseases, or complications that cause | ad the deat | b. Do ==1 - | 299 | Frederi | ck Rd. | Balto | o., MD 21228 | | |
| | ahock, or heart fallure. List only Dna cause Dn | aach ling. | n. Do not a | mar the m | da bi dying, suc | | | interval Between | | |
| | IMMEDIATE CAUSE (Final disease or condition | ner | Un | las | O ni lata () | | | | | |
| i | resulting in death) a | CONSEQU | ENCE OF): | / | 7/ | 1 0 | , | | | |
| Z | Se vire delated androy but | | | | | | | | | |
| HIFICATION | bue to (or as a consequence of): If any, lasding to immediata | | | | | | | | | |
| 5 | CAUSE (Disease or Injury that initiated events DUE TO (OR AS | A CONSEQU | NCE OF): | | | | | | | |
| | resulting in desth) LAST | | | | | | | | | |
| SE | PART II. Other significant conditions contributing to death | had mad and | ulate e te ab | | | | | | | |
| CAL | ()//2, 1971 | DOL HOL 168 | witing in th | | | | RMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE | | |
| | | | 1 🗆 YES | | | 1 TYES | 2 🗍 NO | OF DEATH? | | |
| Σ | DID TORACCO USE CONTRIBUTE TO | CALISE | OF D | EATH | VES [] NC | | | 1 TYES 2 NO | | |
| CIAN | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | | |
| 70 II | EXAMINER? 1 YES 2 HO 1 Inpetient 2 ER/Out | tpatient 3 | | HER: Nursing Ho | me 5 🗆 Residence | 8 Other (Specify) | | | | |
| Ē | 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF | 28c, IA | JURY AT ORK? | 28d. DESCRIBE HOW | INJURY OCCU | URED | | |
| 2 | t | | | M 1 🗆 | YES 2 NO | | | | | |
| 2 | 3 Suicide 6 Could not be building, etc. (Sp. | and Number o | or Rurel Route Number, | | | | | | | |
| - | THE CHITTHEN | | | | | | | | | |
| COMPLE | 2 MEDICAL EXAMINER: On the best of examinati | | | | | | | | | |
| | 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, desth occured at the time, date end place, and due to the ceuse(a) and menner ee stated. 286. SIGNATURE AND TILE OF CERTIFIER 296. DATE SIGNED (Month, Day, Year) | | | | | | | | | |
| D BE | 119 100 Cm | di | P | | De | 7444 | > C | 1/10/45 | | |
| | 30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF A | EATH (KIEM : | Print | ed | . Jull | stan- | M | 521047 | | |
| | 31. DATE FILED (Month, Day, Year) SEP 1 2 1994 Julia Marilla | NATURE | L. | | | | | | | |
| | | - 22 4 | 7 | | | | | | | |



cremation, or

and com o burfal,

the attending physician a Mental Hygiene prior to

signed by the

This cert

31. DATE FILED (Month, Day, Year)

SEP 12 1994

32. REGISTRAR'S SIGNATURE

whi Sanden Ke

BALTIMORE, MARYLAND 21215-0020

| 00 | with |
|---|------------------------------------|
| 6876 | executed |
| \tilde{c} | eg. |
| O. B(| death certificate be executed with |
| ď. | death |
| ŏ | the |
| OR | that |
| REC | requires |
| | AMP. |
| A | The |
| OF VI | PHYSICIAN: |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | SPITAL OR ATTENDING PHYSICIAN |
| ٥ | SPITAL OR |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR 94 ALICE C. RAI 11:45P 09 м 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 1 M 2 VF DAYS HOURS MIN. 219-26-1824 83 YRS. November 15. 1910 Maryland 9a. FACILITY NAME (If not institution, give street and number 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR St. Agnes Hospital Baltimore RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Elkridge Howard 1 TYES 2 X NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6101 Hunt Club Rd. 21227 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 ND IF YES, GIVE WAR DR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yaa or No—
If yea, specify Cuban, Maxican, Puarto Rican, etc.)
1 YES 2 ND Specify: 14. RACE — American Indien, Black, Whita, atc. 1 Never Merried 2 Married ВҰ Specify: 3 🗶 Widowed 4 🗌 Divorced white 16a. DECEDENT'S USUAL OCCUPATION BE COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Nursing 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Clarence Johnson Agnes Meisling 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Raymond Faith, Jr. 6039 Hunt Club Rd., Elkridge, Md. þ 20a. METHOD OF DISPOSITION

1 X Burial 2 Cremation 3 Ram
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, Stata must 9/08/94 remetery cremetory of other place)
Meadowridge Memorial Park Elkridge, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSES examiner 22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 23. PART t. Enter the diseases or complications that caused the daeth. Do not enter the mode of dying, such as cardiac or reapiratory arrest, abook, or heart failure. List only one cause on each line. medical Approximate intarval Between Onsat and Death IMMEDIATE CAUSE (Final the disease or condition DUE TO (DR AS A CONSEDUENCE DF): DISSUCTATION 30 MINS. resulting in death) traumatic event, YOCHRDIAR INICARCTION 1 HOUR CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE DE if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury MIRRIOSCIEROTIC CHROCOVASCULAR 30 YRS. or other DUE TO (DR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Injury, PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any 1 YES 2 ND 1 | YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | SICIAN State Dept 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 | YES 2 | WO 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? H 28b. TIME DF 28d. DESCRIBE HOW INJURY OCCURED marked 1 Netural TO THE HOSPITAL OR ATTENDING PHY
TO THE FUNERAL DIRECTOR: After this
be filed within 72 hours after death wi
IMPORTANT: If Item 28 is marky 5 Pending Investigation 1 YES 2 ND BY 2 Accident 3 Suicide 28a. PLACE DF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, 8 Could not be COMPLETED 4 Homicide 29a. CERTIFIER
(Chack only

1 **LERTIFYING** PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data end place, 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 19/5794 the Ken 26 339 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 30. NAME AND ADDRESS OF PERSON
AS HOK CHOPKA
ST. AGNES HO SPITAL 900 CATON AVENUE. BALTIMORE MARYLAND

12,498 45

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the found of the death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687604

| DWG |
|--|
| FOR STATE REGISTR |
| 1. DECEDENT'S DO RC |
| 4. SOCIAL SECT |
| 90. FACILITY NA 600 |
| RESIDENCE 10e. STATE MD |
| 600 LIG |
| 11. MARITAL ST/ 1 Never Mari 3 XXWidowed |
| |
| |

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| REGISTRAR | | | C | ERTIFI | CATE C | F DEATH | | REG. NO. | | |
|---|-----------------------------------|--|---------------|----------------|---------------------------------------|--|---------------------------------|------------------|---------------------------|--|
| 1. DECEDENT'S NAME (First, N. DOROTHY M. | | SER | | | | | 2. DATE OF MONTH | DAY | YEAR | 3. TIME OF DEATH |
| 4. SOCIAL SECURITY NUMBER | | | OF the second | | | | SEP | | 94 | 4:26P M |
| 215-03-6860 1 □ M 2021 F 74 YRS. | | | | | MONTHS DAT | | 7. DATE OF (Month, D JULY | Day, Year) | 920 B. BIRTT | HPLACE (State or Foreign iny) MD |
| 99. FACILITY NAME (If not institution, give street and number) 600 LIGHT STREET APT. #706 | | | | | | VIN OR LOCATION OF D | DEATH | | COUNTY OF E | DEATH |
| RESIDENCE OF DECE | | | | | | | | | | |
| MD | 10b. COUNTY | | _ | 100 | TIMORE | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| 100. STREET AND NUMBER 600 LIGHT STREI | ET APT. | #706 | | | | 10f. ZIP CODE | 230 | 10: | | WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS 1 Never Married 2 M 3 XXWidowed 4 Divorce | erried | 2. WAS DECEDENT EVI FORCES? 1 1 1 IF YES, GIVE WAR O | ES 2 X | | If yes | DECENDENT OF HISPA , specify Cuben, Mexic YES 2/1/NO Speci | an, Puerto Rici | | 14. RAC Blac Spec | E — American Indian, k, White, etc. |
| 15. DECED (Specify only to | DENT'S EDUCAT | TION mpleted) | | | USUAL OCCUP | ATION most of working | 16b. KI | IND OF BUSINES | SS/INDUSTRY | |
| Elementary/Secondary (0-12 | | College (1-4 or 5 +) | ine | HOMEN | e retired.) | , most or working | - | | | |
| 17. FATHER'S NAME (First, Midd | dle, Last) | | | | | 16. MOTHER'S N. | AME (First, Mide | dle, Meiden Surn | eme) | |
| JOHN T. KAVANAU | | | 10 | h MAII INC | ADDRESS (Po- | ROSE H | | 0° | | |
| MARY T. OWENS | | | j Ï | .607 s. | HANOVE | R STREET, BA | ALT I MORE | MARYL. | AND 2. | 1230 |
| 20s. METHOD OF DISPOSITION M Burlel 2 Cremetion 4 Donetion 5 Other (S | 3 Remova | ol from State | cemetery, cre | ematory or oth | FDISPOSITION her place) MEMORIA | | 9/13 | | ON — CITY OF TO RYLAND | own, State |
| 21. SIGNATURE OF FUNERAL | SERVICE LICEN | ISEE | | | | E AND ADDRESS OF F | | AL LICASE | **** | |
| 1010 | 76 | ed B. | X | | 1501 | ES L. STEVEI E. FORT AVEI | NUE, BAL | TIMORE, | MARYLANI | 21230 |
| 23. PART i. Enter the disc shock, or hea | eases, or cor art fallure. Lis | mplicationa that cause D | n agon fine | esth. Do no | ot entar the | mode of dying, suc | ch as cardia | c or respirato | ry srrest, | Approximate interval Batween |
| iMMEDIATE CAUSE (Final | | 4.4- | | | | | | | | Onset and Desth |
| resulting in death) | 8., | AKTERIO | scu | EKOT | 10 CP | RDIOVAS | CULAI | R PIS | E7485 | |
| | | DUE TO (OR | AS A CONSE | QUENCE OF |): | | | | | |
| Sequentially list condition if any, leading to immedia cause. Enter UNDERLYING | ate | DUE TO (OR | AS A CONSE | OUENCE OF |): | | | | | |
| CAUSE (Disease or Injury that initiated events | | DUE TO (OR / | AS A CONSE | OUENCE OF |); | | | | | |
| resulting in death) LAST | d. | | | | | | | | | |
| PART II. Other significant | conditions | contributing to deal | h but not | regulting is | the under | | Deat la | | | |
| Train in other eigenteens | Conditions | contributing to deal | in but hijt i | eauting in | i the under | ying cause given in | | PERFORMED | ? | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | | — ¹ | ☐ YES 2 | NO | OF DEATH? |
| DID TOBACCO USI | E CONTRI | RUTE TO CAUSE | OF DEA | TH VE | | ☐ UNICEDTAL | N D | | | 1 YES 2 NO |
| 25. WAS CASE REFERRED TO I | | BOIL TO CAUSE | | - | H (Check only o | | ИП | | | |
| EXAMINER? | | OSPITAL: | Outpatient 3 | | OTHER: | tome 5X Naeidence | 8 Other /S | (nec/h/) | | |
| 27. MANNER OF DEATH | | 28a. DATE OF INJU | RY | 28b. TIME | OF 28c. | INJURY AT | | HBE HOW INJUR | Y OCCURED | |
| 1 Natural 5 Pe | nding reatigation | (Month, Day, Ye | mr) | INJU | | WORK? YES 2 NO | | | | |
| 3 Suicide 8 Could not be determined 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28s. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) | | | | | | | Route Number, | | | |
| 29e. CERTIFIER 1 CERTIF | YING PHYSICIA | N: To the best of my k | nowledge, de | ath occurred | d at the time. | date and place, and due | to the causel | s) and manner s | as atated. | |
| | | | | | | | | | | |
| 296 SIGNATURE AND TITLE O | CENTIFICH | 00 () | _ | | | 29c. LICENSE NU | MBER | 290 | I. DATE SIGNED | (Month, Day, Year) |
| Commo | 726 | CL-A | M | | | O.C.M | .E. | | SEPI | |
| MARIO F. G | OLUE | JR M | | | | eet, Bal | timor | e, Ma | ryland | 21201 |
| SEP 1 | 2 1994 | 32. RAGISTRAR'S S | IGNATURE | ment | | | | | | |

| 30X 68760. BALTIMORE, MARYLAND 21215-0020 | The law requires that the death certificate be executed with a cours after death. Page 6 may be retained by the hospital or attending physician. | be detached for use as the burial-transit permit. Pages 1, 2, 3 should | prior to bun'al, cremation, or removal. | 3 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|--|--|--|--|
| ITAL RECORDS, P.O. BOX 68760, | equires that the death certificate be executed within | in signed by the attending physician and completely filled in by | and Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | nows any injury, or other traumatic event, the medic |
| DIVISION OF VITAL R | O THE HOSPITAL OR AFTENDING AND THE TAN 18 | O THE FUNERAL DIRECTOR WHI THE CERTIFICATE THIS DEED | e filed within 72 bours after meth and the State Dept. of | MPORTANT: If item 28 immerked, or item 23 sh |

| | | 1 - FOR STATE REGISTRAR | STATE OF MARYL | LAND / DEPAR CERTIF | RTMENT OF | HEALTH AND F DEATH | MENTAL | HYGIEN | E | |
|--|---------------|--|---|--|---|------------------------|----------------|----------------------------------|------------------------|--|
| | | 1. DECEDENT'S NAME (First, Middle, La | | | | | MONTH | | | 3. TIME OF DEATH |
| | | DARRELL 4. SOCIAL 159-58-4889 | 5. SEX 6. AGE | (In yrs. last birthday) | GAN IF UNDER 1 YEAR | ABLE IF UNDER 24 HRS. | 7. DATE | EMBE I | 1.6 | 1994 6:06P M |
| P | 1 8 | 159 58 4889 | 1 📆 M 2 🗆 F | 37 yrs. | MONTHS DAYS | | Dec. | Dex Year) | 956 | Pennsylvania |
| 3 should | Œ | 9e. FACILITY NAME (If not institution, gi | | | | N OR LOCATION OF D | | | 9c. COUNTY | |
| 1, 2, | RECTOR | JOHNS HOPKINS | | | BALT | , | 1AR Y L | AND | N/A | A |
| Pages | DIRE | PA D | elaware | | ry, town on Localester | CATION | | | | 10d. INSIDE CITY LIMITS? |
| permit. Pages | AL. | 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | <u>.</u> | 10g. CITIZEI | 1 YES 2 X NO |
| . isi | 1 65 1 | 1016 Butler St | | | | 19013 | | | | 5.A. |
| 215-0020 attending physician. se as the burial-transit | BY FUNE | 11. MARITAL STATUS 1 X Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. / FORCES? 1 X YES 2 IF YES, GIVE WAR OR DATES | | | ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yell for year, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X NO Specify: | | | | | . RACE — American Indian, Black, White, etc. Specify: Black |
| or attend | ETED | 15. DECEDENT'S E (Specify only highest gi | (Give kind of | DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working | | | | | | |
| ID 2. spital o | APLE | Elementary/Secondary (0-12) N/A | U.S. | U.S. ARMY | | | ARTIN | ISBUR(| CENTER G,W.VIRGINIA | |
| BALTIMORE, MARYLAND 21215-0020 er death. Page 6 may be retained by the hospital or attending physic the funeral director, page 5 should be detached for use as the buriah val. | <u> </u> | 17. FATHER'S NAME (First, Middle, Last) Perry Gamble | | | 16. MOTNER'S N | AME (First, A | liddle, Maiden | | | |
| ay be retained page 5 should be notified | | 190 INFORMANT'S NAME (NON-Print) | | | | | | | ide) | |
| MORE tage 6 may director, par | | 29a, METHOD OF DISPOSITION 1\(\text{Nurlei} 2 \) Cremetion 3 \(\text{R} \) 4 \(\text{Donation} 5 \) Other (Specify) 21, SIGNATURE OF FUNERAL SERVICE | lemoval from Stata | b. PLACE AND DATE metery, crematory or o HESTER | RURAL | CEMETER | | CHE | STER | , PENNSYLVANIA |
| BALTIMO after death. Page 6 by the funeral directe noval. cal examiner mu | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE PARCH FUNERAL HOME EAST 1101 E. NORTH AVE./BALTIMORE, MD 21202 23. PART I. Enter the diseases, Dr. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | |
| rely filled in bration, or rer | | ahock, or heart fallu iMMEDIATE CAUSE (Finst disesse or condition resulting in death) | a. NARCOTIC, A | each Ilna. | CAINE AND | | | | ratory srreat | t, Approximate interval Between Onset and Desth |
| the certificate be exertificate by exertificate be exertificate by the certificate by the | CERTIFICATION | Sequantially list conditions, if any, leading to immediata cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d | | | | | | | | |
| signed by the atternant and Mental Health and Mental West any Injury, o | CAL | PART II. Other significant condit | ions contributing to death t | but not resulting | in the undarly | ing cause given in | Part I. | 24a, WAS AN PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? |
| E e e e | | DID TOBACCO USE CON | NTRIBUTE TO CAUSE O | OF DEATH Y | S I NO | UNCERTAI | N D | | | 1 TES 2 NO |
| A 25 50 50 | SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE OF DEA | TH (Check only or | | | | | |
| P Value Shirt | 1VSI | 1 X YES 2 NO 27. MANNER OF DEATN | 1 ☐ Inpatient 2 € ER/Out | patient 3 DOA | | ome 5 - Residence | - | (Specify) | | |
| O I ME | I | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | UNKNO | JURY \ | VORK? | UNKNO! | | JURY OCCUR | NEO . |
| OIVISION OR ATTENDATION DIRECTOR BETT Sours after Bettt | ETED B | 3 Suicide 6 (X) Could not determined | be 26s. PLACE OF INJURY building, stc. (Spe | Y - At home, term, | atreet, fectory, of | fice | C/ty c | TION (Street e r Town, State) | nd Number or i | Rural Route Number, |
| 4 4 2 m | 립 | | YSICIAN: To the best of my know | | | | | | | euse(e) end menner ee stated, |
| TO THE HOSPIT TO THE FUNER be filed within 7 | BE | 296. SIGNATURE AND TITLE OF CERTIF | (1) night | | | 29c. LICENSE NU | | | | IGNED (Month, Day, Year) |
| F F 3 5 | 2 | 30. NAME AND ADDRESS OF PERSON | WHO COMPLETED CAUSE OF DE | EATN (ITEM 27) (Type | Print) | LO.C.M | I. Pi | | SEPT | EMBER 9. 199 |
| | | DONALD G. WRI | GHT M.D. | | n Stre | eet, Bal | timo | re, N | Maryl | and 21201 |
| | | SET 12 1334 | I win Davidem 1 | | | | | | | |

BALTIMORE, MARYLAND 21215-0020

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| | 1 - FOR STATE REGISTRAR | OF MARYLAND / I | DEPARTMENT OF RTIFICATE OF | | MENTAL HYGIENI | E | | | | |
|----------------------|---|--|---|-----------------------------|---|------------------|---|--|--|--|
| 1000 | 1. DECEDENT'S NAME (First, Middle, Last) | H. G1 | an | | 2. DATE OF DEATH MONTH DA | Y - GH | 3. TIME OF DEATH | | | |
| OR | 4. SOCIAL SECURITY NUMBER 5. SEX 1 M 2 | | YRS. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTN (Month, Day, Year) 11/20/19 | Coun | HPLACE (State or Foreign ry) CHMOND, VA | | | |
| TOR | 9a. FACILITY NAME (If not institution, give street and num LIBERTY MEDICAL CE RESIDENCE OF DECEDENT | | 96. CITY, TOWN OR LOCATION OF DEATH BALTIMORE 9c. COUNTY OF DEATH | | | | | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY MARYTJAND | | 10c. CITY, TOWN OR LOC | | - | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | | | |
| FUNERAL | 100. STREET AND NUMBER 1622 BALMORE COUR | т | 1 | 01. ZIP CODE 21212 | | 10g. CITIZEN OF | | | | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 X Married FORCE | ECEDENT EVER IN U.S. ARM S? 1 X YES 2 NO GIVE WAR OR DATES | | CENDENT OF HISPAN | NIC ORIGIN? (Specify Yas in, Puarto Rican, etc.) | or No- 14. RAC | E — American Indian, k, Whita, atc. | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elamentary/Secondary (0-12) 12th College (| EDENT'S USUAL OCCUPATE of kind of work done during in Do NOT use retired.) | | 16b. KIND OF BUS | INESS/INDUSTRY | 2201 | | | | |
| E COM | 17. FATNER'S NAME (First, Middle, Last) Linwood Gray | | | | ME (First, Middle, Maiden S | | | | | |
| TO BE | 19m. INFORMANT'S NAME (Type/Print) Ella Bella Martin G | ray 29 | MAILING ADDRESS (Street 007 Mosss | and Number or Rural de Ave | Route Number, City or Town | d, Virg | 23222 jinia | | | |
| | 20a. METNOD OF DISPOSITION 1 Burfal 2 Cremellon 3 X Ramoval Irom State 4 Donation Other (Specify) Other (Specify) Date Date 20c. LOCATION - City or Town, State Quantico National Cem. 9/16 Quantico, Virginia | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSPE | Quet | 1 1 22. NAME / LERO 4600 | NND ADDRESS OF FA | CILITY YETT & SOI Y HEIGHT: | N FUNER | ALHOME | | | |
| | 23. PART I her tha disease of compileations that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, interval Batween Onest and Death disease or condition a. Approximate interval Batween Onest and Death Toulust Approximate interval Batween Onest and Death Onest | | | | | | | | | |
| CERTIFICATION | disease or condition reaulting in death) a. Could Renul faulticle DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): ATTHEOSCIENTAGE DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other algorificant conditions contributions | ting to death but not re | aulting in tha underlyl | ng cause givan in | AUTOPSY WERE AUTOPSY FINDINGS WED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | |
| CIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | AL: | | PLACE OF DEATH (Ch | eck only one) | | | | | |
| HYS | | HOSPIFAL: 1 Properient 2 ER/Outpetient 3 DOA 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED | | | | | | | | |
| ВУ Р | 1 Natural 5 Pending 2 Accident Investigation | Month, Day, Year) | M 1 | YES 2 NO | | TINJURY OCCURED | | | | |
| ΙEΟ | 3 Suicide 8 Could not be 4 Nomicide 8 Could not be datarmined 28e. PLACE OF INJURY — At home, tarm, strast, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the one) 2 MEDICAL EXAMINER: On the bit | | | | | | s) and manner as atated. | | | |
| TO BE C | 296. SIGNATURE AND TITLE OF CERTIFIER FMILLIUM | Kuldis | | | | 29d. DATE SIGNED | (Month, Day, Year) | | | |
| - | Franklin 5 f | ED CAUSE OF DEATH (ITEM | 27) (Type, Print) Md. | 924u | , north. | Aue B | alto, mil | | | |
| | SEP 1 2 1994 | THE SIGNATURE | | | | | | | | |

ALC: THE

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TETONCE
31. OATE FILEO (Morith, Day, Year)
SEY 12 1334

32. REGISTRAR'S SIGNATURE

| | | 1 - FOR STATE REGISTRAR | STATE OF MARYLAND | DEPAR | TMENT OF | HEALTH AND | MENTAL HYGIEN | | 26481 |
|--|--------------|--|---|-----------------|--------------------------------|---|---|--------------|---|
|) | | t. OECEDENT'S NAME (First, Middle, Last) | CADSEN | | | | 2. DATE OF DEATH | " q'i | 3. TIME OF DEATH 4.25-PM |
| B | | 10 010 | 5. SEX 8. AGE (In yrs. Ia | yns. | IF UNDER 1 YEA MONTHS DAY | | 7. DATE OF BIRTH (Month, Day, Year) | 3 | BIRTHPLACE (State or Foreign Country) |
| 2, 3 should | TOR | 9a. FACILITY NAME (if not institution, give str | cal Center | | 96. CITY, TOW | N OR LOCATION OF D | EATH | 9c. COUNTY | OF DEATH |
| t. Pages 1, | DIRECTOR | 10a. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN OF LO | CATION | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| n. Insit permit. | ERAL | 3505 White | Chapel Ro | al | | 101. ZIP CODE 2/2/5 | | 10g. CITIZEN | OF WHAT COUNTRY? |
| by the hospital or attending physician, be detached for use as the burial-transit at once. | BY FUNER | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. AFFORCES? 1 TYES 2 TIF YES, GIVE WAR OR DATES | | If yes, | Specify Cuban, Maxico ES 2 NO Specific | | or No — 14. | RACE - American Indian, Black, White, atc. Specify: Bladk |
| spital or attend hed for use as | OMPLETED | 15. OECEDENT'S EDUC, (Specify only highest grade of Elementary/Secondary (0-12) | ompleted) (C | ive kind of a | vork done during the retired.) | ATION most of working | Dunk | | yh School |
| d by the hospit id be detached d at once. | BE CON | 17. FATHER'S MAME (First, Middle, Last) | Gladden | | | 18. MOTHER'S N | ME (First, Middle, Maiden | Surname) | |
| ay be retained to page 5 should be notified | 10 E | Jessie B. Gle | adden | 350 | 5 W | rite Cha | pel Rode | Pa Ba | to red 21215 |
| age 6 may director, pa er must t | | 20a METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Remote 4 Donation 5 Other (Specify) | ral from State | AND DATE | place / | (Name of Cess | 913/9x /1 | ne A | or Town, Stata |
| r death. F he funeral al. examin | | 21. SIGNATURE OF PIMERAL SERVICE LICE | Chron | | You | AND ADDRESS OF FA | Wabash | Au | 4 |
| within 25 npletely fille cremation. | | 23. PART I. Enter the diseases, or conshock, or heart fellure. L. IMMEDIATE CAUSE (Final disease or condition resulting in death) | proficetione that caused the desist only one cause on each line Jenuary OUE TO (OR AS A CAUSE | 1. | phase | Λ | | h net | Approximata Interval Between Onset and Death |
| certificate be executing physician and lygiene prior to bur other traumation | ERTIFICATION | Sequantielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST | DUE TO (OR AS A CONSE | WE | Ty T | tailne | | | |
| the d We | AL C | PART II. Other algnificent conditions | contributing to deeth but not | resulting | in the underly | ing cause given in | Part I. 24s. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO |
| OR ATTENDING PHYSICIAN: The law requires that the Inflection After this certificate has been signed by the first that the State Dept, of Health and the 23 shows any little 23 shows any little 23 shows any little 23 shows any little 23 shows any little 23 shows any little 23 shows any little 23 shows any little 23 shows any little 23 shows any little 23 shows any little 23 shows any little 23 shows any little 24 shows any l | MEDIC | | | | | | 1 YES 2 | | COMPLETION OF CAUSE OF DEATH? |
| he law reques has been to Dept, of Im 23 sho | SICIAN: | DID TOBACCO USE CO | | SE OF | | YES 4 NC | | | |
| SICIAN: The lar certificate has the State Dept 1, or Item 23 | IYSIC | | HOSPITAL: | 1 | | ome 5 - Rasidenca | | | |
| DING PHYSI After this c death with | ву рну | 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIM INJ | URY | INJURY AT WORK? | 26d. OEŞCRIBE HOW I | NJURY OCCUR | ED |
| ATTENDIA ECTOR: After de | | 3 Suicide 8 Could not be determined | 28s. PLACE OF INJURY — At he building, atc. (Specify) | ome, farm, a | street, tactory, o | ffica | 26f. LOCATION (Street a City or Town, State) | | lural Route Number, |
| HOSPITAL OR RUNERAL OR WITH TO THE | OMPL | | AN: To the best of my knowledge, do: On the besis of examination and/or | | | | | | use(a) and manner as stated, |
| TO THE HO TO THE FU be find wit |) BE c | 296 SIGNATURE AND TITLE OF CERTIFIED | alm. D | | | 29c. LICENSE NUI | MBER 203 | 29d. DATE SH | SNED (Month, Day, Year) |
| | 2 | 30. NAME AND ADDRESS OF PERSON WHO | | М 27) (Туре, | Frint) | | 1 7 | 1 | 1001 |

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| BALLIMONE, MANICAMO ZIZIS-0020 | ENDING PHYSICIAN: The law requires that the death certificate be executed within roours after death. Page 6 may be retained by the hospital or attending physician. | s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should the State Dept, of Health and Mental Hygiene prior to bunial, cremation, or removal. | the medical examiner must be notified at once. | |
|--|---|---|---|--|
| CONTRACTOR OF THE COURSE, T.O. BOX 081 001 | TO THE HIGH MILL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within | TO THE CHERT, DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the miles with the Cate Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT II Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |

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|---------------|--|---|--|------------------|---------------------------|---|--------------------|------------------------------|--|--|
| | FOR 1 STATE | STATE OF MARY | | | | MENTAL HYGIEN | E | | | |
| | REGISTRAR | | CERTIF | ICATE C | OF DEATH | REG. NO. | | | | |
| | 1. OECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH MONTH DA | AY YĘA | 3. TIME OF DEATH | | |
| DIRECTOR | Catherine | V. Gra | ıy | | | Sept 6 | 1994 | 11:50 M | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AG | E (In yrs. last birthday) | IF UNDER 1 YE | | 7. DATE OF BIRTH | 8. B | HRTHPLACE (State or Foreign | | |
| | 579-07-8655 | 1 M 2 XF | 79 YRS. | MONTHS DA | YS HOURS MIN. | (Month, Day, Year) March 23 | | Wash, D.C. | | |
| | 9e. FACILITY NAME (# not Institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH | | | | | | | 9c. COUNTY OF DEATN | | |
| | Anne Arundel Medical Center Annapolis | | | | | | | Anne Arundel | | |
| | RESIDENCE OF DECEDENT | | | | | | | | | |
| Ä | 10c. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? | | | | | | | | | |
| | Maryland Anne | Arunder | Chu | rento | n | | | 1 TES 2 NO | | |
| AL | 10e. STREET AND NUMBER | - | | | 10f. ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? | | |
| FUNERAL | 5416 Deale Chu | archton Ro | ad | | 20733 | | U.S. | Α. | | |
| 3 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | IN U.S. ARMED | 13. WAS | DECENDENT OF NISPAN | IIC ORIGIN? (Specify Yea | or No 14. F | RACE American Indian, | | |
| | 1 Never Married 2 Married | FORCES? 1 YE | S 2 NO | II yes | , specify Cuban, Mexica | n, Puerto Ricen, etc.) | | Black, White, etc. | | |
| BY | 3 Widowed 4 Divorced | | DAI CO | 1 | YES 2 NO Specify | <i>f.</i> | " | White | | |
| | 15. DECEDENT'S EDUC | CATION | 16a. OECEDENT'S | USUAL OCCU | PATION | 16b. KINO OF BUS | SINESS/INDUSTR | RY | | |
| E | (Specify only highest grade Elementary/Secondery (0-12) | College (1-4 or 5+) | life. Do NOT u | se retired.) | most of working | | , | | | |
| 릴 | 12 | | В | ookke | eper | Bookk | eepin | g | | |
| COMPLETED | 17. FATNER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S NA | ME (First, Middle, Malden | Sumame) | | | |
| | Henry Thomas H | loff | | | Irene | Louise I | angle | У | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | AOORESS (Str | eet end Number or Rural F | Route Number, City or Town | n, Stete. Zio Code | 2) 00570 | | |
| 2 | Jacqueline Fras | ser | 1265 | Lott | ie Fowler | r Rd.Prin | ice Fr | ederick, MD | | |
| | Jacqueline Fraser 1265 Lottie Fowler Rd. Prince Frederick, MD 200. METNOD OF OISPOSITION 2015. PLACE AND DATE OF OISPOSITION (Name of OATE 200. LOCATION — City or Town, Sinte | | | | | | | | | |
| | 1 Surial 2 Cremation 3 Rame 4 Donation 5 Other (Specify) | | ashingt | | | | /10 Suitland, MD | | | |
| | 21. SIGNATURE OF FUNEYAL SERVICE LIGHNSEE | | | | | | | | | |
| | Hardesty Funeral Home, PA 12 Ridgley Ave, Annapolis, MD 21401 | | | | | | | | | |
| Ш | · vac ja | · // L | - 01 | | | | | , MD 21401 | | |
| | 23. PART i. Enter the diseases, or contact the enterty of the ente | complications that cause | ed the deeth. Do | not enter the | mode of dying, sucl | h as cerdiec or respi | ratory srrest, | Approximate | | |
| | IMMEDIATE CAUSE (Fine) | | | | | | | | | |
| | disease or condition resulting in death) s. CARDIO PULMONARY ARREST Sm DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| z | Sequentielly list conditions, b. SUB ANACHNOW HEMORETAGE Day | | | | | | | | | |
| 은 | If sny, leeding to immediate | | | | | | | | | |
| 3 | cause, Enter UNDERLYING CAUSE (Disease or injury | · CPILBI | BLAL | AN | 10645 | 1)11 | | Y BAR | | |
| 틸 | that initiated events | DUE TO (OR AS | A CONSEQUENCE O | F): | 7 | | | | | |
| CERTIFICATION | resulting in deeth) LAST | | | | | | | | | |
| I ~ I | PART II, Other significent conditions contributing to death but not resulting in the underlying cause given in the lander of the | | | | | | | | | |
| Ĭ. | PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO | | | | | | | | | |
| ă | 1 U YES 2 WO COMPLETION OF CAUSE OF DEATH? | | | | | | | | | |
| MEDICAL | 1 🗆 YES 2 🗆 NO | | | | | | | | | |
| z | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 26. PLACE OF DEA | | one) | | | | | |
| YSI | 1 TYES 2 HO | 1 Inputlant 2 ER/OL | stpatient 3 DOA | OTHER: | Home 5 - Residence | 6 Other (Specify) | | | | |
| H | 27. MANNER OF OEATN | (Month, Day, Year) | 28b. TIM | E OF 28c. | INJURY AT WORK? | 28d. OESCRIBE HOW II | NJURY OCCURE | 0 | | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | NONI | 3 | | YES 2 NO | | | | | |
| | 3 Suicide 8 Could not be | 28s. PLACE OF INJUI building, etc. (Sc | RY — At home, Jerm, | straet, Jactory, | office | 281. LOCATION (Street a City or Town, State) | nd Number or Ru | iral Route Number, | | |
| 2 | 4 Homicide datermined | | | | | ony or lown, state) | | | | |
| 3 | 29a. CERTIFIER | CIAN: To the beat of my kno | owledge, death occurr | ed at the time. | date and place, and due | to the cause(s) and men | ner es stated | | | |
| COMPLETE | | | | | | | | rse(s) and manner as stated. | | |
| | 296. SIGNATURE AND TITLE OF CENTIFIES | 001 |) | | | | | | | |
| BE | Latotal | 141 | 4 | | 29c. LICENSE NUM | 3742 | DATE SIGN | NED (Month, Day, Year) | | |
| 임 | 30. WAND ADOBUSE OF CEBSON, WHO | O CONTRACTOR CAUSE OF I | DEATN (ITEM 27) (Type | Print) | 1 11- | /ヘイン | 7 | 0.17 | | |
| | Van Jerry | CELLINGE | STOP OF THE PROPERTY OF THE PR | 72/~ | Α. | 0 11. | · 1/ | 10 - Wall | | |
| . 1 | 31. DATE EILED (Month, Day Mar) | 1 22. REGISTRAR'S SIG | MATURE | 110 | Thun | 4,011 | 7 | (1) X/ TU/ | | |
| | SEP 1 2 1994 | Jakin Danisan- | Pardade | | | V | | | | |
| | T. T. 20. | 7 | - | | | | | | | |

| rSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | The secretariant has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the star finet of Health and Mental Hydiene prior to burial, cremation, or removal. | nedical examiner must be notified at once. |
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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 no | TO THE FUNERAL DIRECTED. The following physician and completely filled in by the filled within 72 hours are completely filled in by the filled within 72 hours are completely filled in by the filled within 72 hours. | MPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | FOR STATE REGISTRAR | | MARYLAND / | DEPAR | TMENT (| OF HEALT | H AND | | YGIENI EG. NO. | E | | | |
|-------------------------------|--|---|--|---|---|--|--------------------|--|--|-----------------------------------|---|-----------|--|
| , | ALICE MIH ARRIS SEPTEMBERO 1994 | | | | | | | | | | TIME OF DEATH | | |
| | 4. SOCIAL SECURITY NUMBER 229-01-1219 | 5. SEX | 8. AGE (In yrs. lac | | IF UNDER 1 Y | YEAR IF UND | ER 24 HRS. | 7. DATE OF E (Month, De | BIRTH B. BIRTHPLACE (State Country) 14 6-23-20 VA | | | | |
| TOR | 96. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DEATH 96. COUNTY OF DEATH 96. COUNTY OF DEATH 96. COUNTY OF DEATH | | | | | | | | | | гн | | |
| DIRECTOR | BALTIMORE CITY | | | | | | | | Dd. INSIDE CITY LIMITS? | | | | |
| FUNERAL | 100. STREET AND NUMBER 2201 WALBROOK | | - | 101. ZIP CO | | | | - | USA | AT COUNTRY? | | | |
| ă I | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC DRIGHT? (Specify Yes or No-Hispanic Dright? (Specify Yes or No-Hi | | | | | | | | Vhita, atc. | | | | |
| COMPLETED | 15. DECEDENT'S EDI (Specify only highest gradi Elementary/Secondary (0-12) | | (G | | se retired.) | JPATION ing most of wor | king | 16b. KIN | D OF BUS | INESS/IND | DUSTRY | | |
| BE CO | 17. FATHER'S NAME (First, Middle, Last) FRANK JOHNSON 18. MOTHER'S NAME (First, Middle, Maiden Surmarne) PEARL GLOVER JOHNSON | | | | | | | | | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) BOSIE FOXX | | 3 | 6. MAILING | ADDRESS (S | RD AVE | er or Rural BAL | Route Number, C | , MD | , State, Zip • 212 | Code) 207 | | |
| | 20e. METHOD OF DISPOSITION 1 | DE DISPOSITION | ON (Name of | DATE 20c. LOCATION — City or Town, State 9/14 BALTO . MD. | | | | | | | | | |
| | 21. SIGNATURE OF EUREBLE SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. BROWN COMMUNITY F/H 1206 W North AVE | | | | | | | | | | | | |
| | Approximate shock, or heart failure list only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due To (or AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST b. ISCHEMIC CARBIO HUOPATY DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| MEDICAL | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AWALABLE PRIOR TO COMPLETION DF CAUSE OF DEATHY 1 YES 2 NO | | | | | | | | | | | | |
| | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: | | | | | | | | | | | | |
| SICIAN | EXAMINER? | | 44 | | | | | | | | Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED | | |
| r PHYSICIAN | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 M Netural 5 Pending | HOSPITAL: 1 M Inpatient 2 28e. DATE OF (Month, Da | INJURY | 28b. TIM | 4 Nursing E OF 28 URY | c. INJURY AT WORK? | , | | | JURY OCC | CURED | | |
| ≽ // | EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH | 28a. DATE OF (Month, Di | INJURY | 28b. TIM | 4 Nursing E OF 28 URY | c. INJURY AT WORK? | Residence NO | | BE HOW IN | | | e Number, | |
| ≽ // | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Metural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only | 28e. PLACE Of building, | INJURY ny. Year) F INJURY — At ho etc. (Specify) | 28b. TIM INJ me, farm, s | 4 Nursing E OF 28 URY M 1 street, factory, | c. INJURY AT WORK? I YES 2 , office | NO NO | 28d. DESCRIE 28f. LOCATION City or To | N (Street ar wn, State) | nd Number | or Rural Roul | | |
| TO BE COMPLETED BY PHYSICIAN: | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only 1 CERTIFYING PHYS | 28e. DATE OF (Month, Did building, ICIAN: To the best of ER: On the basia of ax | INJURY ny, Year) F INJURY — At ho etc. (Specify) my knowledge, de amination and/or i | 28b. TIM INJ me, farm, s ath occurre | 4 Nursing E OF 28 URY M to street, factory, and at the time n, in my opin | c. INJURY AT WORK? I YES 2 , office , data and place fon, death occ | NO NO | 28d. DESCRIE 28f. LOCATIO City or To to the cause(s) time, data and | N (Street arwn, State) and menn place, and | nd Number mer as state dua to the | or Rural Roul ed. e cause(a) ar | | |

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| | | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | AND / DEPART | | | MENTAL | HYGIENE REG. NO. | | | | • |
|--|----------------|--|---|--------------------------------------|---------------------------------|--------------------------------|------------------------------------|---------------------------------|---------------|-------------------------|-----------------|----------|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | OF DEATH | | 3. 1 | TIME OF DEAT | ТН |
| | | CHRISTOPHER | | | HALE | | SEPT | | | 994 | 4:05 | Ам |
| 5-6-1 | | 4. SOCIAL SECURITY NUMBER 225-02-1153 | 5. SEX 6. AGE (II | in yrs. lest birthday) YRS. | IF UNDER 1 YEAR | IF UNDER 24 HRS, HOURS MIN. | 7. DATE ((Month) | DE BIRTH Day, Year) 10/59 | 8. | BIRTHPLAC Country) | CE (State or Fo | oreign |
| 3 should | | 9a. FACILITY NAME (If not Institution, give : | | | 9b. CITY, TOWN | OR LOCATION OF D | | | e. COUNTY | | | |
| 1, 2, 3 8 | DIRECTOR | UNTON HOSPITAL | | | ELKTON | V | | | CEC | :IL | | |
| ages | | 10a. STATE 10b. COUNT | | 10c. CITY, | TOWN OR LOCA | TION | | | | 10d | . INSIDE CITY | ٧ |
| Į. | | New Mexico S 100. STREET AND NUMBER | anta Fe | | | Santa | Fe | | | | YES 2 | NO |
| 020 physician. burial-transit permit. Pages 1, 2. | UNERAL | 2801 Calle De | Sonora | | 10 | H. ZIP CODE 875 | 505 | 1 | 10g. CITIZEN | USA | COUNTRY? | |
| Siciar rial-tra | FU | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN FORCES? 1 YES | U.S. ARMED | 13. WAS DEC | CENDENT OF HISPA | NIC ORIGIN | ? (Specify Yea or | No- 14. | . RACE — A Black, Wh | American India | an, |
| YLAND 21215-0020 by the hospital or attending physician. be detached for use as the burial-traat once. | COMPLETED BY F | 1 Never Merried 2 Merried 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR DA | ATES | | S 2 XNO Speci | | ican, ec., | | Specify: | | |
| 215-00 attending | | 15. DECEDENT'S EDU | | 18a. DECEDENT'S U | SUAL OCCUPATION | ON | 16b. | KIND OF BUSIN | ESS/INDUS | | White | <u>e</u> |
| 2121 al or att | | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of wo life. Do NOT use | ork done during mo retired.) | ost of working | | | | | | |
| ND hospit ached | | 10 | | Brake | Mecha | nic | | Auto | Repa | irs | | |
| LAN the hore | | 17. FATHER'S NAME (First, Middle, Last) | 77 1 | | | 16. MOTHER'S NA | | | | | | |
| MARYLAND retained by the hospit 5 should be detached notified at once. | BE | Joseph F. 19a. INFORMANT'S NAME (Type/Print) | нате | | DDD500 (0) | | | y Lee | | | | |
| ORE, MAR e 6 may be retained ector, page 5 should must be notified | 2 | Betty L. Del V | alle | | | and Number or Rural Sonora | | a Fe, N | | | 8750 | 5 |
| may be or, page ast be r | | 20s. METHOD OF DISPOSITION 1 □ Burlal 2 ▼ Cremation 3 □ Ram | 20b. | PLACE AND DATE OF | DISPOSITION / No | eme of | DATE | 20c LOCA | TION — City | | | |
| BALTIMOR after death. Page 6 mis by the funeral director, moval. | | 4 Donation 5 Other (Specify) | Me | etery, cremetory or other cre | er plece) emator | y, Inc. | 9/10 |) Ba | 1tim | ore, | MD | |
| ALTIMO death. Page 6 e funeral directo al. | | 21. SIGNATURE OF FUNERAL SERVICE LI | ENORE OF S | 41 | C. T. O.TO | ation S | ACILITY | tw of | ма | In | 0 | |
| BAL er dear the fur val. | | George E. | MacNabb | | 299 | Frederi | ck R | d. B | alto | , III | D 21: | 228 |
| 2 2 2 | | 23. PART I. Entar tha diseases, or | | I tha death. Do no | t antar tha mo | oda of dylng, suc | ch as card | lac or respirat | ory arrest | | Approxima | ata |
| filled in | | IMMEDIATE CAUSE (Final | | | - | | | | | | Onset and | |
| ted with completely filled ial. cremation. o | í | disease or condition resulting in dasth) | a. Multipo | 1/2 1/ | nuri | <i>es</i> | | | | | | |
| 68760, ecuted with and complet burial, cren | _ | | DOE TO (OR,AS A | CONSEQUENCE OF | | | | | | | | |
| × 8 E E | RTIFICATION | Sequantially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| D.O. BOX n certificate be of nding physician Hygiene prior to or other traun | CA | CAUSE (Disease or Injury | | | | | | | | | | |
| | | that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST | | | | | | | | | | |
| ± 6 – | Ë | d | | | | | | | | | | |
| RDS, at the deal by the att and Menta y Injury, | AL. | PART II. Other significant condition | is contributing to death bu | ut not resulting in | the underlyin | g cause given in | Part I. | 24a. WAS AN AU PERFORME | | | E AUTOPSY FI | |
| Meduires that the speed signed by the pt. of Health and 1 shows any In. | EDIC | | | | | | _ | 1 NES 2 | NO | | PLETION OF C | CAUSE |
| RECOI requires that seen signed of Health a shows any | Σ | DID TOP ACCOUNT CONT | | | | | | | | 1 🕾 | TES 2 1 | МО |
| AL F has be Dept. | AN | DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL | | F DEATH YES 26. PLACE OF DEATH | | | ΝЦ | | | | | |
| 一年 書書 書 | SICI | EXAMINER? | HOSPITAL: | | OTHER: | | e [] en | | | | | |
| LL 을 중축 등 | PHY | 27. MANNER OF DEATH | 28a, DATE OF INJURY | 28b, TIME | OF 28c, INJ | ne 5 🗆 Rasidenca JURY AT | | (Specify) | JRY OCCUR | ED | | |
| N O B PHYS ler this of the with with marked | BY | 1 Netural 5 Pending 2 Accident Investigation | 9-10-94 | 323 i | | YES 2 NO | subj | ect run | over 6 | 49 00 | 1 | |
| 0 0 4 9 3 | 8 | 3 Suicide 8 Could not be 4 Homicide detarmined | 28e. PLACE OF INJURY building, etc. (Speci | - At home, ferm, atr | | | TION (Street and r Town, State) | Number or I | Rural Route | Nymber 2 | 13 | |
| 2 E B # 82 | <u> </u> | | | Street | | | Ce | eit 6 | Hd | l | , | |
| P 352 | COMPL | and the same to th | ICIAN: To the best of my knowle | | | | | | | | | |
| (Y) | 8 | | R: On the basis of axamination | end/or investigation. | in my opinion, d | death occured at the | time, date | and place, and d | lue to the ci | suse(s) and | manner as si | Acted. |
| TO THE TO THE THE MPORT | B | 29b. SIGNATURE AND TITLE OF CERTIFIE | 1 10/ + | | | 29c. LICENSE NU | | | | | ith, Day, Year) | |
| E 5 3 ₹ | 2 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF DEA | 114 (ITEM 27) (Time 5 | Print) | 0.C. | M.E. | | SEPTE | MBER | 10, 1 | L994 |
| (3) | | Dennis J. Chut | | | | Baltimo | oro 1 | Aarrel an | A 212 | 01 | | |
| | | 31. DATE FILED (Month, Day, Year) SEP 1 2 1994 | 32. REGISTRAR'S SIGNA | ATURE | DITEGE! | рателік | TE' L | JOT A TOUR | u 212 | .01 | | |
| | | SEP 1 2 1994 | John Dandem-Ra | what | | | | | | | | |

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MARYAMOR

31. OATE FILED (MO)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

A. Koper

32. PEGISTRAR'S SIGNATURE Lis Dendem-Re

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH VEAD JAMES N. HORSEY 3rd. .09 SEPT 1994 03:12 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) a. BIRTHPLACE (State or Foreign DAYS HOURS YRS. 214-96-2753 25 06-29-69 MARYLAND Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR JOHNS HOPKINS HOSPITAL BALTIMORE city none RESIDENCE OF DECEDENT 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND NONE BALTIMORE CITY 1 X YES 2 | NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Page 6 may be retained by the hospital or attending physician. al director, page 5 should be detached for use as the burial-transit 341 E. 20TH STREET 21218 UNITED STATES 11. MARITAL STATUS 12, WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 JNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 It yes, specify Cuben, Mexican, Puerto Rican, etc.) X Never Married 2 Married 1 TES 2 NO B Specify 3 Widowed 4 Divorced African American COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 10TH DISH WASHER RESTAURANT 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) JAMES N. HORSEY, JR. BE PAMELA POMPEY notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 21217 PAMELA HORSEY DOLPHIN STREET BALTIMORE MARYLAND þe 20a. METHOD OF OISPOSITION
1 Burlai 2 Crametion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must funeral director, MT. ZION, CEMETERY 9-14-94 4 ☐ Constitute 8 ☐ Other (Specify) BALTIMORE, MARYLAND medical examiner OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY CALVIN B. SCRUGGS FUNERAL HOME urs after death. 1412 E. PRESTON ST. BALTO, MD. completely filled in by the 23. PART i. Entar the diseases, or complications that caused the de th. Do not anter the mode of dying, such as cardisc or respiratory srrest, shock, or heart failure. List only one cause on each line interval Between 9 IMMEDIATE CAUSE (Final (MULTIPLE GUNSHOT WOUNDS) Onset and Death the disease or condition MULTIPLE GUNSHOT resulting in death) other traumatic event, crem DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEQUENCE OF): burial, CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF) prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS signed by t Health and AVAILABLE PRIOR TO COMPLETION OF CAUSE shows any 1 NYES 2 THO OF OEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has be Dept. HOSPITAL DR ATTENDING PHYSICIAN: The faw 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h EXAMINER? OTHER: 1 | Inpatiant 2 | ER/Outpatiant 3 | DOA 8 - Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED marked, 94 1 Natural 5 Pending EMB 120-1 HOL ΒY 9 0245A" DIRECTOR: After 1 hours after death death 2 Accident 28a. PLACE OF INJURY — building, atc. (Specify) 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) WID 8 Could not be COMPLETED 20th ST+BARCLAY BANNORUM 4 Momicide 28 Silver 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated, FUNERAL WITHIN 72 h 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as attended. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 1 SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Mouporte One Thele

DHMH-16 Rev 1/89

SEPT 09 1994

OCME

111 Penn Street, Baltimore, Maryland 21201

60 BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 54 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | MENTAL HYGIENE REG. NO. |
|--|---|----------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH |

| | TIEGIOTTIAIT | | 921111 | I OAIL | JI DEAIII | HEG. NO | | | |
|---------------|--|---|--------------------------------|---------------------|--|--|------------------------|----------------------------------|--|
| 1 | 1. DECEDENT'S NAME (First, Middle, Lest) OTTALIE HOLTZMAN Ottalie Beatrice Holtzman 2. DATE OF DEATH MONTH 09 08 1994 8: | | | | | | | | |
| 35 | 4. SOCIAL SECURITY NUMBER | | (In yrs. lest birthde | | | 7. DATE OF BIRTH | a, BIR | THPLACE (State or Foreign | |
| | 216-03-9925 | 1 □ M 2 💢 F | 82 YRS | MONTHS D | WE HOURS MIN. | January 2 | 9,19 200 | Maryland | |
| ~ | 9a. FACILITY NAME (If not institution, give s | | | 9b. CITY, TO | WN OR LOCATION OF D | EATH | 9c. COUNTY OF | | |
| ē | Greater Baltimor | e Medical Ce | nter | | Towson | to. | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY 10c. CITY, TOWH OR LOCATION 10d. | | | | | | | | |
| | Maryland | | | Baltim | ore , City | | | LIMITS? 1 X YES 2 HO | |
| RAI | 100. STREET AHO HUMBER | A., o | | | 101. ZIP CODE 212 | 10g. CITIZEH O | WHAT COUNTRY? | | |
| FUNERAL | 2805 Overland 11. MARITAL STATUS | AVE. 12. WAS DECEDENT EVER | IN U.S. ARMED | 13. WAS | DECEMBENT OF HISPAI | | 8 Or No.— 14 84 | V. J. M. NCE — American Indian, | |
| BY F | 1 Hever Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 YES | 2 NO DATES | I1 ye | s, specify Cuban, Maxica YES 2X HO Specif | n, Puerto Rican, etc.) | Bi | white, etc. | |
| | 15. OECEDENT'S EDU (Specify only highest grade | | 16a. DECEDENT | T'S USUAL OCCU | PATION | 16b. KIHD OF BU | SIHESS/INDUSTRY | | |
| COMPLETED | Elamentary/Secondary (0-12) | College (1-4 or 5+) | | | ng most of working | Over | Home | | |
| OME | 17. FATHER'S HAME (First, Middle, Last) | | ПОШ | emaker | 18. MOTHER'S HA | ME (First, Middle, Maider | | | |
| BE C | Arthur Eckhardt | | | | Lill | | khardt | | |
| 10 B | 19a. IHFORMANT'S HAME (Type/Print) | | | | reet and Number or Rural | | | | |
| - | Ronald A. Eckhar | | | | 26th. Str | | | | |
| | 20a. METHOO OF DISPOSITION 1 Surial 2 Cremation 3 Ram 4 Donation 5 Other (Specify) | noval from Stale | metery, crematory of all timor | other place) Cemet | | 1 | alto. Mo | | |
| | 21. SIGHATURE OF FUNERAL SERVICE LICENSEE Milton of Knight Jr Leonard J. Ruck, Inc. | | | | | | | | |
| | Multon | Knight | k. | 530 | 5 Harford | Rd. 21214 | | | |
| | 23. PART i. Entar tha diseasea, or complications that caused the death. Do not anter the mode of dying, such as cardiec or reapiretory arrest, ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due TO (DR AS A COHSEOUEHCE OF): Approximate interval Between Onset and Death Cause of Complications and Death | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d | | | | | | | | |
| AL O | PART ii. Other significant condition | na contributing to death | but not resultin | g in the unde | lying cause given in | Part i. 24a. WAS AI | | 4b. WERE AUTOPSY FINDINGS | |
| EDICAL | PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSO OF DEATH? | | | | | | | | |
| AN: M | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X7 | | | | | | | | |
| SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER: | 88. PLACE OF DEATH (Ch | eck only one) | | | |
| HYS | 1 YES 2 HO 27. MAHHER OF DEATH | 1 Phoetient 2 ER/Ou 28a. DATE OF INJURY | | | Home 5 Rasidence | 8 ☐ Other (Specify) 28d. DESCRIBE HOW | H HIRY OCCURED | | |
| ВУ Р | 1 Hatural 5 Pending Investigation | (Month, Day, Year) | | INJURY | WORK? | 200. DESCRIBE NOW | MISORY OCCURED | | |
| ETED E | 3 Suicide 6 Could not be 4 Homicide datermined | 28a. PLACE OF IHJUF building, atc. (Sp | tY — At home, farr ecify) | n, street, factory, | offica | 281. LOCATIOH (Street City or Town, State | and Number or Run) | al Route Number, | |
| COMPLE | | ICIAN: To the best of my kno | | | | | | e(s) and manner as stated. | |
| TO BE C | 29b. SIGNATURE AND TITLE OF CHITTEE | led in | | | 29c, LICEHSE NU | 2849 | 19- | ED (Month, Day, Year) -9-94 | |
| ٦ | 30. HAME AND ADDRESS OF PERSON WITH AND CONTROL OF THE STATE OF THE ST | O, MD. | EATH (ITEM 27) (7) | pe, Print) 054 | ER D | Tows | ou 1 | 40 21204 | |
| | 31. DATE FILED (MODIF), Day, (bar) 32. REGISTRARIS SIGNATURE SEP 1 2 1994 32. REGISTRARIS SIGNATURE | | | | | | | | |

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BALTIMORE, MARYLAND 21215-0020

| TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attends |
|--|
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as it |
| be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

TO BE COMPLET

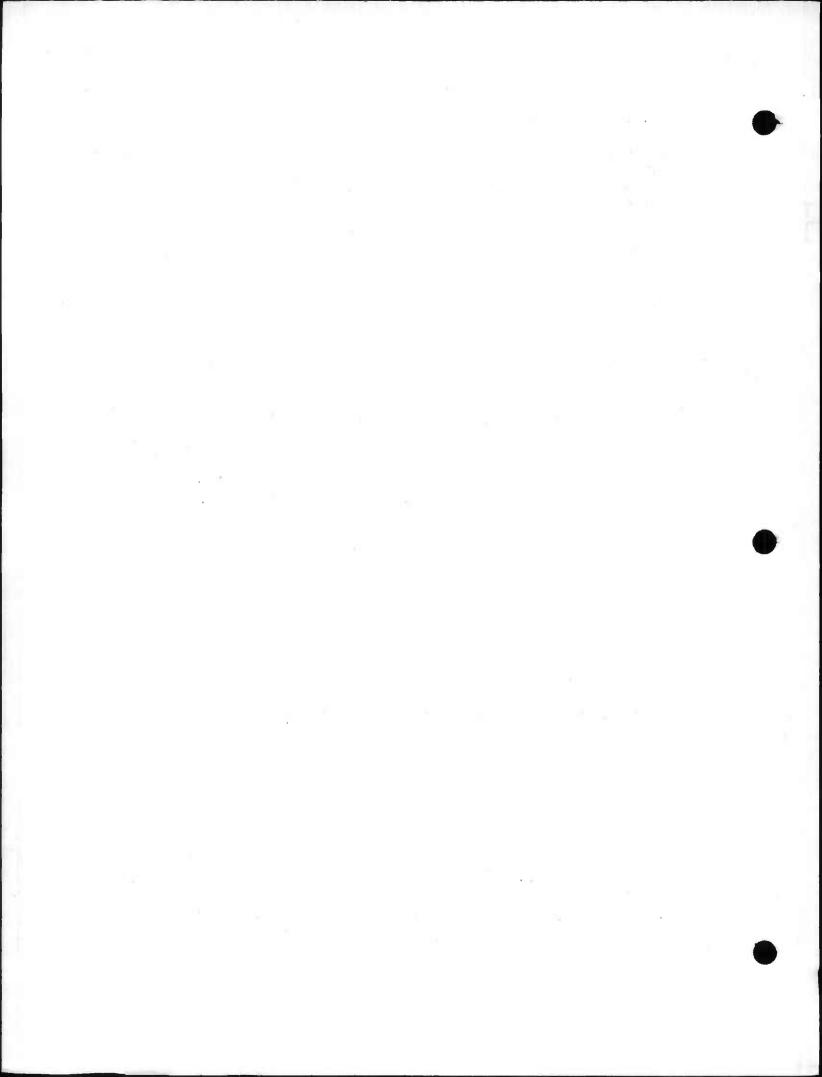
| | FOR 1 STATE | STATE OF I | MARYLAND / | DEPAF | RTMENT O | HEALTH | AND | MENTAL HYGIEN | | 4 8 | 26487. |
|--------------|---|------------------------------|-------------------------------------|------------------------|----------------------------------|---------------|-----------|---|------------|-------------------|---|
| | - REGISTRAR | | | | ICATE C | | | REG. NO | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | mmos z | | | | | | 2. DATE OF DEATH MONTH D | AV | YEAR | 3. TIME OF DEATH |
| | JOYCE MARIE HAMPTON | | | | | | | | 7/ 19 | | 6.20 A M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. le: | | MONTHS DAY | | R 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | , | Country | PLACE (State or Foreign |
| | 220-60-8332 | 1 🗆 M 2 💢 F | 37 | YRS. | | | | April 19, | 1957 | | yland |
| <u>~</u> | 9s. FACILITY NAME (if not institution, give street and number) | | | | | N OR LOCAT | ION OF DI | EATH | | INTY OF DE | |
| DIRECTOR | Stella Maris Hos | spice Cel | nter | | Tow | son | | | Ba | ltimo | re |
|) H | 10a. STATE 10b. COUNT | Y | | 10c. CIT | Y, TOWN OR LO | CATION | | | - | | 10d. INSIDE CITY |
| | Maryland Ha | rford | | H | lavre d | le Gra | ice | | | | LIMITS? |
| ₹ ¥ | 10e. STREET AND NUMBER | | | | | 10f. ZIP COD | E | | 10g. CIT | | HAT COUNTRY? |
| FUNERAL | 123 S. Washington | | | | | 21 | 078 | | 1 | USA | |
| J. | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDEN | T EVER IN U.S. AF | IMED NO | 13. WAS | Specify Cubi | OF HISPAN | NIC ORIGIN? (Specify Yes | or No- | 14. RACE Black | - American Indian, White, etc. |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE Y | WAR OR DATES | | 10 | ES 2 NO | Specif | y: | | Specif | White |
| | 15. DECEDENT'S EDU | | 16a. DE | CEDENT'S | USUAL OCCUP | ATION | | 16b. KIND OF BU | SINESS/IN | OUSTRY | *************************************** |
| ETI | (Specify only highest grade Elementary/Secondary (0-12) | completed) College (1-4 or 5 | life | ive kind of a Do NOT u | work done during se retired.) | most of worki | ng | | | | |
| COMPLETED | 12 | | | Sec | retary | | | Educ | ation | 1 | |
| 9 | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOT | HER'S NA | ME (First, Middle, Maiden | Sumame) | | |
| BE (| James F. Thomas | <u> </u> | | | | E | vely | n Coyne | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | . T | | | | | | Route Number, City or Tow | | | 000 |
| | George M. Hamp | | | | | | ı St | ., Havre | | | |
| | 205 METHOD OF DISPOSITION 1 Burlel 2 Cremetton 3 Rem 4 Donetton 5 Other (Specify) | | 206. PLACE | Metogray PHII | of disposition | tery | | 9/12 Br | | yn, I | wn, Stata Maryland |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | . Han | eston | , la | Mitc | | mith | Funeral F Ce, Maryla | | , P.A | Α. |
| | 23. PART I. Enter the diseeses, or o | complications the | ceueed the de | ath. Do | not enter the | mode of dy | Ing, auc | h aa cerdlec or reep | retory an | reet, | Approximate |
| | ahock, or heert failure. IMMEDIATE CAUSE (Finel | List only one cer | use on each line | . | | | | | | | Interval Between Onset and Death |
| | disease or condition resulting in deeth) | Mal | Hirent | 200 | Ac | La | | 2 | | | 87 ==== |
| | Touching in dooring | DUE TO | (OR AS A CONSE | OUENCE O | f): | /3 (3) | | Lona | | | 030043 |
| Z | Sequentially list conditions, | b | | | | | | | | | |
| ERTIFICATION | if any, leeding to immediate cause. Enter UNDERLYING | DUE TO | (OR AS A CONSE | OUENCE O | F): | | | | | | |
| 를 일 | CAUSE (Diseese or injury | c. DUE TO | (OR AS A CONSE | OUENCE O | fi. | | | | | | |
| E | that initiated eventa resulting in death) LAST | | (0111011021 | ocitor o | , ,. | | | | | | j |
| CE | | d | | | | | | | | | |
| MEDICAL | PART II. Other algnificent condition | e contributing to | deeth but not i | reculting | in the underl | ing cause | given in | Part I. 24s. WAS AN PERFOR | | 24b. | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO |
| ă | | | | | | | | 1 _ YES 2 | -NO | | OF DEATH? |
| | | | | | | | | _ | | | 1 YES 2 -HO |
| AN | DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL | CONTRIBUT | E TO CAU | SE OF | | |] NC | | | | |
| PHYSICIAN: | EXAMINER? | HOSPITAL: |] ED/O-4 | | OTHER: | PLACE OF E | | | | | |
| H X | 27. MANNED OF OEATH | 28a. DATE OF | ER/Outpatient 3 | 26b. TIN | | INJURY AT | asidence | 6 Softher (Specify) 28d. DESCRIBE HOW I | N'ILIBA VV | CIBED | |
| ВУ РІ | 1 Natural 5 Pending 2 Accident Investigation | (Month, E | Pay, Year) | IN. | JURY M 1 | WORK? YES 2 | □ NO | 250. SECONDE NOW 1 | | JONED | |
| | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE (building | oF INJURY - At ho atc. (Specify) | me, term, | street, factory, o | ffice | | 28f. LOCATION (Street a City or Town, State) | and Numbe | r or Rural R | oute Number, |

29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN:

| 96. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. OATE SIGNED (Month, Day, Yea |
|--|---------------------|-----------------------------------|
| () Alarges (flott 15) | D23446 | > 9/9/94 |
| a wast fun appoint or propositions come come of the com- | | |

31. DATE FILED (Month, Day, Year) SEP 1 2 1994

32 REGISTRAR'S SIGNATURE

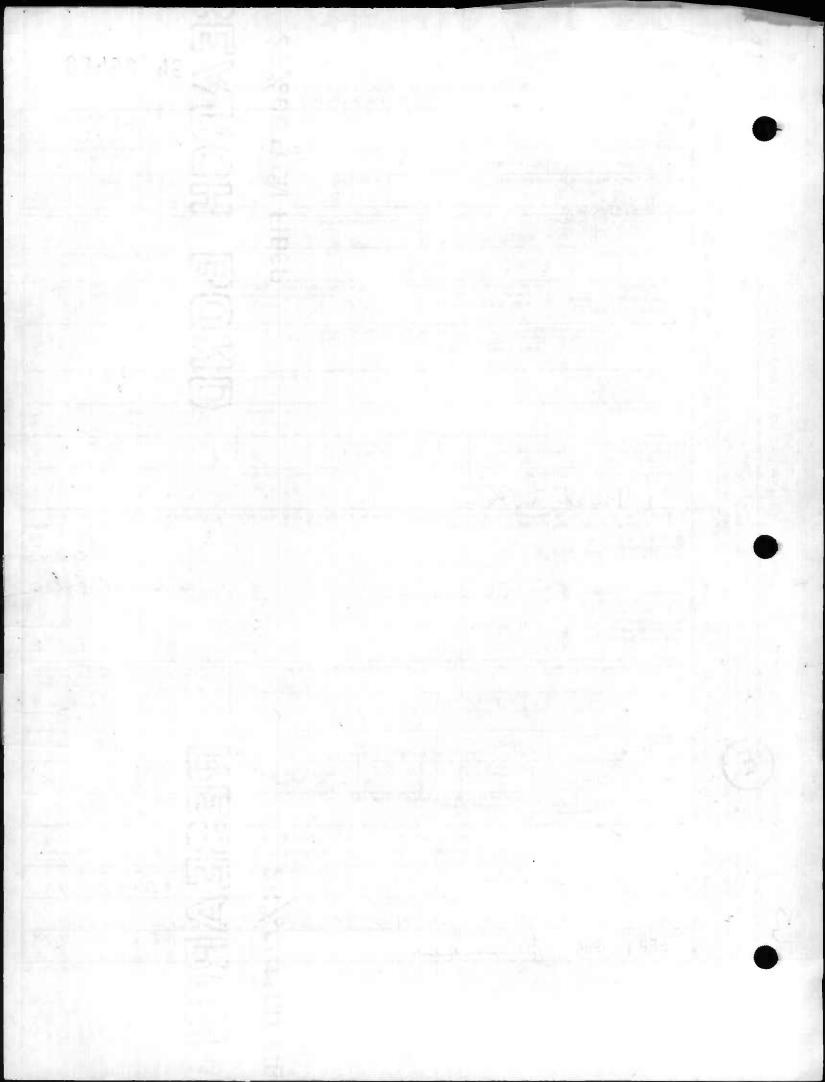


| DIVISION DENUTAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020 | L OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed with ours after death. Page 6 may be retained by the hospital or attending physician. | DIRECTOR: After this coolingate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should hours after dear, with the Gay Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. |
|--|---|---|
| X 68760, | ne executed with | an and completely filler to burial, cremation, |
| DS, P.O. BO | he death certificate b | the attending physical Mental Hygiene prior |
| L RECOR | law requires that | as been signed by bept, of Health and |
| DEMITA | PHYSICIAN: Ne | this certify are h with the Star |
| DIVISION | L OR ATTENDING | L DIRECTOR; After hours after dear |

TO THE FUNERAL DIRECTOR; After the Filed within 72 hours after death

9 4
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1 - FOR STATE REGISTRAR | STATE OF MARY | LAND / DEPARTI Certific | IENT OF HEALTH AN | MENTAL HYGIENE | | | | | | |
|------------------|---|--|--|--|--|---|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 100 | 2. DATE OF DEATH DAY | YEAR 3. TIME OF DEATH | | | | | |
| | ANNIE M.JOH | | d | | 09 08 | 94 1155 PM | | | | | |
| | 213-62-6080 | 1 □ M 2 🖟 F | 94 YRS. MC | UNDER 1 YEAR IF UNDER 24 HR NTHS DAYS HOURS MIN | DEC18, 189 | 9 S. CAROLINA | | | | | |
| OR | MERCY HOSPIT | Street and number) FAL | 9 | BALTIMORE | DEATH | COUNTY OF DEATH | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | ry | | 10d. INSIDE CITY | | | | | | | |
| | MARYLAND | n/a | | BALTIMORE | | 1 X YES 2 NO | | | | | |
| FUNERAL | 100. STREET AND NUMBER 2327 N. | CHARLES S | STREET | 10f. ZIP CODE 21218 | | NITED STATES | | | | | |
| BY | 11. MARITAL STATUS 1 Never Merried 2 Merried 3XXWidowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR | 2 Np | If yes, specify Cuben, Me: | PANIC ORIGIN? (Specify Yes or steam, Puerte Rican, atc.) | No— 14. RACE — American Indian, Black, White, etc. Specify: B L A C K | | | | | |
| COMPLETED | 15. DECEDENT'S EDI (Specify only highest gred | le completed) | 16a, DECEDENT'S US (Give kind of work life, Do NOT use n | done during most of working | 16b, KIND OF BUSINE | SS/INDUSTRY | | | | | |
| 4PL | Elementary/Secondary (0-12) | 4 YEARS | DOME | STIC | n/ | a | | | | | |
| 111 | 17. FATHER'S NAME (First, Middle, Last) THOMAS HA | ZEL | | 18. MOTHER'S | NAME (First, Middle, Malden Surr A MC MILL | AN | | | | | |
| 5 | 199. INFORMANT'S NAME (Type/Print) HAZEL BOO | KER | 196. MAILING AD 1622 | E BIDDLE | STREET, | BAZ TIMORE, MD#13 | | | | | |
| | 20b. PLACE AND DATE OF DISPOSITION 1/ Deuriel 2 Cremeilon 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Other (Specify)) 20b. PLACE AND DATE OF DISPOSITION (Name of Other (Specify)) 20b. PLACE AND DATE OF DISPOSITION (Name of Other (Specify)) 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSME 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | |
| | WM. C. MARCH FH1101 E. NORTH AV | | | | | | | | | | |
| AL CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) PNEUMONIA Bodays Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| AL AL | PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? PERFORMED? 1 YES 2 NO 1 YES 2 NO | | | | | | | | | | |
| SICIAN: MEDIC | | | | | | DF DEATH? | | | | | |
| CIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | 26. PLACE OF DEATH | (Check only one) | | | | | | |
| IYSI | 1 TYES 2 M NO | HOSPITAL: | tpatient 3 DOA 4 | ce 6 Other (Specify) | | | | | | | |
| 급 | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | | 28d. DEŞCRIBE HOW INJU | RY OCCURED | | | | | |
| TED | a Dautette | 2 Accident 3 Suicide 6 Could not be building, etc. (Specify) 28e. PLACE OF INJURY — At home, lerm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street end Number or Rural Route Number of Bural Route Number of Rural Route Nu | | | | | | | | | |
| E COMPLETED | | | | | due to the cause(e) end manner the time, date and place, and du | ee stated. ue io the ceuse(e) end manner es stated. | | | | | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIE | ER | | 29c. LICENSE | NUMBER 29 | nd. DATE SIGNED (Month, Day, Year) | | | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WI | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | |
| - | 1 1 | | | | | | | | | | |
| | ARTURO MO 31. DATE FILED (MONTH, Day, Year) | NTE IRO | JR. M.O | . MERCY H | tospital 301 | ST PAUL PLACE BALT. MD 21201 | | | | | |



BALTIMORE, MARYLAND 21215-0020

412

| ng physician. | he burial-transit permit. Pages 1, 2, 3 | | |
|---|---|-------------------------------------|--|
| hours after death. Page 6 may be retained by the hospital or attending physician. | : FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 | | |
| nours after death. Page 6 | etely filled in by the funeral directo | emation, or removal. | -A Ab |
| HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with | the attending physician and compl | Mental Hygiene prior to burial, cri | 10 10 10 10 10 10 10 10 10 10 10 10 10 1 |
| HYSICIAN: The law requires that t | is certificate has been signed by | with the State Dept. of Health and | 1 10 to 10 t |
| HOSPITAL OR ATTENDING P. | FUNERAL DIRECTOR: After th | within 72 hours after death v | A |

1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATN YEAR 4 JOHN SON MILDRED 4 SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 9/26/1904 89 Balto., MD 217-16-8063 1 M 2 X F Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH MERCY HOSPITAL DIRECTOR BALTIMORE RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 16g, CITIZEN OF WHAT COUNTRY? 3647 FOREST HILL ROAD 21207 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2. NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No --14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: В Specify: Black 3 Widowed 4 Divorced COMPLETED 16e, DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5 +) Scott's Family Domestic 6th 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Surname) Annie Johnson BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 3647 Stewart Monroe Forest Hill Road Baltimore, MD 21207 e 20e. METHOD OF DISPOSITION

1 (X Buriel 2 (A Cremetion 3 Gremoval from State 4 Green of 5 Green of 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Mo" Naclonal Cemetery 9/12 Laurel, Maryland examiner 21. SIGNATURE OF FUNERAL BERVICE LICEN 22. NAME AND ADDRESS OF FACILITY
I.EROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207 medical shock, or heart fally complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between **Onset and Death** IMMEDIATE CAUSE (Final 9 disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF Y5 Candiac CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediata cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF) CAUSE (Disease or Injury that initiated events resulting in death) LAST gestue 0 PART II. Other algoriticant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL sel3 are COMPLETION OF CAUSE 1 TES 3 NO OF DEATH? Brean 1 TYES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) EXAMINER? HOSPITAL: OTHER:
4 Nursing Name 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending м 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, ferm, atreet, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number City of Town State) 8 Could not be determined 69 COMPLETED 4 Homicide 28 TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If Item 2 CERTIFIER (Check only a CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(s) and menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c LICENSE NUMBER BE Pritting 1 129998 19-885 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

2101 CLONT LN # 211 The Manual Research UNE



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

L DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within reforms after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. TO THE PARTILL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a fours after death. Page 6 may be retained by the hoss to the page 10 miles in by the funeral director, page 5 should be detached the page 10 miles after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

WPORTANT I liem 28 is marked, or flem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | | | 7 | 4 6 | 64 | 90 | |
|--|-----------------------------|---------------------|------------------------------------|--|----------------|------------|---|-------------|---------------|----------------------------|---------------|--|
| FOR 1 - STATE REGISTRAR | STATE OF M | IARYLAND / | DEPARTMERTIFIC | TENT OF H | IEALTH DEAT | AND M | ENTAL HYGIE | | | | | |
| 1. DECEDENT'S NAME (First, Middle | Lest) | | | | | | 2. DATE OF DEATN | | 1 | 3. TIME OF | DEATH | |
| Gilbert | Т. | Ja | ckson | | | | | DAY 2. 1 | 994 | 6:30 | A # | |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (In yrs. le: | st birthday) IF | UNDER 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF BIRTH | | 8. BIRTH | PLACE (State | | |
| 224-32-1277 | 15 M 2 □ F | 84 | YRS. | NTHS DAYS | HOURS | MIN. | an.4, | 910 | Sout | Éh Ca | aroli | |
| 9e. FACILITY NAME (If not institution | , give street and number) | | 96 | CITY, TOWN | OR LOCATIO | | | 9c. CO | UNTY OF DI | _ | | |
| Mercy Hospit RESIDENCE OF DECEDER 100. STATE MD 10b. C | | | _ [| Balt | timo | re | | | | | | |
| RESIDENCE OF DECEDER | OUNTY | | | | | | | | | | | |
| MD | Seve | | ION | | | | | 10d, INSIDE | 5? | | | |
| 10e. STREET AND NUMBER | | | | | . ZIP CODE | | | 1 40 - 01 | | 1 YES | | |
| 1822 Dove Co | unt | | | 100 | 2114 | | | 10g. Cr | | VNAT COUNT | HY? | |
| 11. MARITAL STATUS | 12. WAS DECEDENT | EVER IN II C AC | PMED. | | | | | | USA | | | |
| 1 Never Married 2 Married | FORCES? 1 | YES 2 | MO JMED | It yes, sp | ecify Cuban | , Maxican, | ORIGIN? (Specify Y Puerto Rican, etc.) | es or No — | Black | — America , White, etc. | • | |
| 3 😾 Widowed 4 🗌 Divorced | IF YES, GIVE W | AH OH DATES | | 1 U YES | 2 KNO | Specify: | | | Specif | Specify: White | | |
| 15. DECEDENT (Specify only highes | | 16a, DE | ECEDENT'S USL | JAL OCCUPATION | ON | | 16b. KIND OF B | USINESS/IN | DUSTRY | | | |
| Elementary/Secondary (0-12) | College (1-4 or 5+ | | live kind of work Do NOT use re | done during mo tired.) | st of working | 7 | | | | | | |
| 6 | | Gro | oom | | | | Rac | e Ho | orse | | | |
| 17. FATHER'S NAME (First, Middle, L. Unknown | | 1 | · | | 18. MOTN | ER'S NAME | E (First, Middle, Maide | in Surname) | | | | |
| OHRHUWH | Jac | kson | | | | U | Inknown | | | | | |
| 19a. INFORMANT'S NAME (Type/Print | | 19 | b. MAILING AD | G ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dove Court, Severn, MD 21144 | | | | | | | | |
| Joseph Jacks | 011 | | 1822 L | ove (| Court | t, S | evern, | MD | 2114 | 14 | | |
| 20a, METHOD OF DISPOSITION ★ Burial 2 □ Cremation 3 | Ramoval from Stata | 20b. PLACE | AND DATE OF D | ISPOSITION (Na | me of | | OATE 20c. L | | - City or Ton | | | |
| 4 U Donation 5 U Other (Specify | 1 6 | Epipi | rany the | | | | | | on, M | | | |
| 21. SIGNATURE OF PUNERAL SELECTION | CELICENSEE /// | | | Hard | D ADDRES | Fun | eral Ho | me. | P.A | | | |
| Dat 1 | Chyr | | | 12 R | idge. | ly A | venue, | Anna | apol | is, 1 | MD 21 | |
| 23. PART I. Enter the disease | a, or complications that | caused the de | eath. Do not | enter the mo | de of dyir | ng, auch | aa cardiac or rea | piratory a | rreat, | Appr | roximate | |
| IMMEDIATE CAUSE (Final | ilure. List only one caus | | | | | | | | | | vai Between | |
| disease or condition resulting in death) | Acu | te my | same | ia/ In | fore | Man | suspe | ched | 1 | | | |
| resolving in destri) | DUE TO (| OR AS A CONSE | OUENCE OF): | | -1 | | | | | 1 | | |
| | To At | horescla | neho | hear | nr | dis | en-e | | | | | |
| Sequentielly list conditions, if any, leading to immediate | OUE TO | OR AS A CONSE | OUENCE OF): | | | | | | | | | |
| CAUSE (Disease or injury | · | hienil's | Appro 1 | Fib | 11/9. | HRI | | | | | | |
| that initiated eventa resulting in death) LAST | 00E TO (| OR AS A CONSE | OUENCE OF): | ahsh | u mh | 0 / | my disa | 2110 | | | | |
| | d. / e/ | M/May C | _ N/M// C | Cioni | | | 1 | - 3 - | | | | |
| PART II. Other aignificent con | ditions contributing to | death but not i | reaulting in ti | ne underlyin | g ceuse gi | ven in Pa | art i. 24a. WAS A | | 246. | WERE AUTO | PSY FINOINGS | |
| Ventilator c | rependent | chmic | respir | atery | Jesil | we | PERFO | RMED? | | | N OF CAUSE | |
| | | | | | | | _ | 1 19 110 | | OF DEATN? | | |
| DID TOBACCO USE CO | ONTRIBUTE TO CAL | JSE OF DEA | TH YES | Пиог | 1 UNCE | RTAIN | | | | | 110 | |
| 25. WAS CASE REFERRED TO MEDI- | CAL | | CE OF DEATH (| | | - | | | | | | |
| EXAMINER? | HOSPITAL: | ER/Outpatient 3 | DOA 4 | HER: Nursing Hom | e 5 🗆 Res | Idenca 8 | Other (Specify) | | | | | |
| 27. MANNER OF DEATH | 28s. DATE OF (Month, De | | 285. TIME OF | 28c. INJ | | | Red. OEŞCRIBE NOW | INJURY O | CCURED | | | |
| 1 Natural 5 Pending 2 Accident Investig | 7 | y/ | INSORT | | res 2 | NO | | | | | | |
| 3 Suicide 8 Could n | 28s. PLACE OF building, s | INJURY — At ho | ome, farm, atree | t, factory, offic | 0 | 2 | eat, LOCATION (Stree | and Number | er or Rural R | oute Number, | : | |
| 4 Nomicide datermi | | (opcony) | | | | | City or Town, State | "/ | | | | |
| 29a. CERTIFIER 1 CERTIFYING | PHYSICIAN: To the best of a | ny knowledge, de | ath occurred at | the time, data | and place. | and due to | the cause(s) and m | nner as at | Med. | | | |
| | AMINER: On the basis of ax | | | | | | | | | and manna | er an stated. | |

29c. LICENSE NUMBER
D30492

Baltimore MD &1224



TO BE

296. SIGNATURE AND TITLE OF CERTIFIER

31. DATSEPMT" 201994

DUSAI

NWO

ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATN (ITEM 27) (Type, Print)

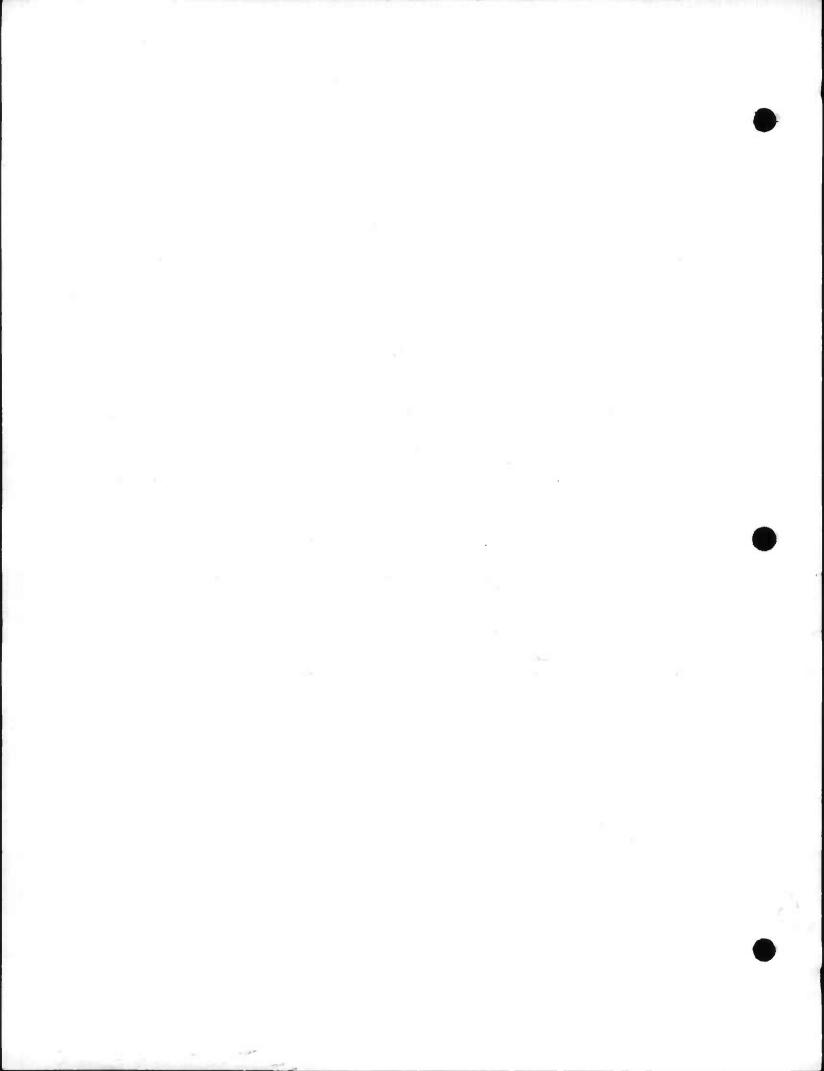
4660

32. REGISTRAR'S SIGNATURE

wilkensAre

29d. DATE SIGNEO (Month, Day, Year)

9/2/94



TO BE COMPLETED BY FUNERAL DIRECTOR

FOR

PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED IMPORTANT: If item

| STATE OF MARYLAND / DEPARTMENT OF HEALTH ANI | MENTAL | HYGIEN |
|--|--------|----------|
| CERTIFICATE OF DEATH | | REG. NO. |

| 1 - STATE REGISTRAR | | CERTIFIC | ATE OF D | EATH | REG. NO. | | | | |
|---|---|---|--|-----------------------------|--|------------------------|----------------------|---|------|
| 1. DECEDENT'S NAME (First, Middle, Last) MATILDA PEARL KNIC | HT | | | | 2. DATE OF DEATH September | [*] 6, 1 | 554 | 3. TIME OF DEATH 5:15 A. | М |
| 212-07-2856 | □ M 2XXF | | | UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) 11-12-03 | | 6. BIRTHI Country | PLACE (State or Foreig | gn |
| 9a. FACILITY NAME (If not institution, give street 15 N. Milton Avent | | 9 | Baltimor | | ATH | 9c. COUN | TY OF DE | EATH | |
| RESIDENCE OF DECEDENT 10a. STATE Maryland | 100 | | rown or location | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| 3512 Mt. Pleasant | Avenue | | | 21224 | | 10g. CITIZ | | HAT COUNTRY? | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 2. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR | S 2- NO | If yes, specify | | C ORIGIN? (Specify Yea , Puarlo Rican, etc.) | or No- | Black | - American Indian, White, atc. | |
| 15. DECEDENT'S EDUCA (Specify only highest grade co Elementary/Secondary (0-12) | | 16a. DECEDENT'S US (Give kind of work life. Do NOT use of Housey | k done during most of etired.) | f working | 16b. KIND OF BUS | INESS/INDU | USTRY | | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph Krantz | - | | 16 | | ME (First, Middle, Maiden : Welnicki | Sumame) | | | |
| 19e. INFORMANT'S NAME (Type/Print) Gregory A. Weaver | | 196. MAILING AT | Milton A | Number or Aural A Venue, | oute Number, City or Town Baltimore | , State, Zip , Md . | ^{Code)} 212 | 224 | |
| 20e METHOD OF DISPOSITION 1 Description Burlel 2 Cremetion 3 Remove 4 Donation 5 Other (Specify) | al from State | ob. PLACE OF DISPOSITE other place) Holy Redeer | ner Cemet | tery | Bal | cation — c | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICEN | see | eus | Matther | | ral Home Ave., Balt | imore | e, Má | 1. 21224 | |
| ahock, or heert feilure. Li iMMEDIATE CAUSE (Finei disease or condition resulting in death) Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR AS | B A CONSEQUENCE OF): B A CONSEQUENCE OF): B A CONSEQUENCE OF): | | | | | | Interval Batt | |
| PART II. Other algnificent conditions Poss with un | | | | | 000000 | MED? | 24b. | . WERE AUTOPSY FINI AVAILABLE PRIOR TO COMPLETION OF CAI OF DEATH? | USE |
| 1 YES 2 NO 27. MANNER OF DEATH 1. Netural 5 Pending 2 Accident Investigation | HOSPITAL: Inputient 2 ER/O 26e. DATE OF INJUR (Month, Dey, Year | utpatiant 3 DOA 4 | OTHER: Nursing Home OF 28c, INJURY WORK t YES | Y AT | | | | Dougla Number | |
| 3 Suicide 8 Could not be detarmined 29e. CERTIFIER Check only | building, atc. (S | pecify) | | d place, and due | City or Town, State) | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO | On the basis of examina | tion and/or investigation, | In my opinion, deat | | tima, data and place, an | d due to th | e cause(a | (Month, Day, Year) | led. |
| 3508 BAVK S | 32. REGISTRAR'S SI | -To, mel | | 24 | | | | | |
| SEP 12 1334 | munanism- | moule | | | | | | | |

31. DATSEPMT#72°1994

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| BALTIMORE, MARYLAND 21215-0020 | retained | 5 should |
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| BOX 687 | cate be executed | hysician and com |
| D. BOX 687 | rtificate be executed | ng physician and com |
| .O. BOX 687 | certificate be executed | nding physician and com |
| , P.O. BOX 687 | leath certificate be executed | attending physician and com |
| DS, P.O. BOX 687 | he death certificate be executed | the attending physician and com |
| RDS, P.O. BOX 687 | hat the death certificate be executed | by the attending physician and com |
| ORDS, P.O. BOX 687 | is that the death certificate be executed | ined by the attending physician and com |
| ECORDS, P.O. BOX 687 | juires that the death certificate be executed | signed by the attending physician and com |
| RECORDS, P.O. BOX 687 | requires that the death certificate be executed | seen signed by the attending physician and com |
| AL RECORDS, P.O. BOX 68760, | ne law requires that the death certificate be executed within motiours after death. Page 6 may be retained by the hospital or attending physicia | has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tr |

an. transit permit. Pages 1, 2, 3 should TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Flours after death. Page 6 may be retained by the hoss TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filed within 72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to burial. cremation. or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL

| | L.R.B. | | | | | | | | 9 | 4 | 26492 | |
|--|--|---------------------------------------|----------------------------------|------------|---------------|-------------------|-------------|--|--------------|--------------------|---|--|
| | FOR 1 - STATE REGISTRAR | STATE OF MARY | LAND / DEPAI CERTIF | | | | | MENTAL HYGIEN | _ | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | DEA | | 2. DATE OF DEATH | | | 3. TIME OF DEATH | |
| | JOSEPH | V. | | KI | RONE | R, JE | 2 | SEPT 08 | | YEAR | 6:04P M | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AG | E (In yrs. lest birthday) | | ER 1 YEAR | IF UNDER | | 7. DATE OF BIRTH | | 8. BIRTH | PLACE (State or Foreign | |
| | 218 94 9105 | ½ □ M 2 □ F | 29 YRS. | MONTHS | DAYS | HOURS | MIN. | April 2, | .965 | Mar | yland | |
| ~ | 9a. FACILITY NAME (If not institution, give st | reet and number) | | | Y, TOWN O | | | ATH | | c. COUNTY OF DEATH | | |
| 5 | 517 PATUXENT | AVE | | C | hesac | o Pa | rk | | Baltimore | | | |
| EC | 10a. STATE 10b. COUNTY | | 10c. Cl | TY, TOWN | OR LOCATI | ON | | | | T | 10d, INSIDE CITY | |
| DIRECTOR | Maryland Ba | | | esaco | | C | | | LIMITS? | | | |
| Too. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF W | | | | | | | | | | | | |
| | | | | | | | | SA | | | | |
| J. | 11. MARITAL STATUS | 12. WAS DECEDENT EVER FORCES? 1 YE | R IN U.S. ARMED | 13 | . WAS DECE | NDENT OF | HISPAN | HC ORIGIN? (Specify Yes | or No- | 14. RACE | - American Indian, | |
| ВУ | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR | | | 1 YES | | | n, Puarto Rican, etc.) | | Specif | - American Indian, White, etc. y: White | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | CATION completed) | 18a. DECEDENT'S (Give kind of | work done | during mos | N t of working | | 16b. KIND OF BUS | SINESS/IND | USTRY | | |
| | Elementary/Secondary (0-12) | College (1-4 or 5+) | Me. Do NOT | ecn: | anic | i or worning | , | Вон | ling | Lane | es | |
| MP | 11 | | | | | | | | | | | |
| BE CO | 17. FATHER'S NAME (First, Middle, Last) Joseph V. | Kroner, Sr. | | | | | | ME (First, Middle, Meiden ICES M. Zir | | | | |
| TO B | Joseph V. Kroner, | Sr. | 196. MAILIN | ADDRE | s (Street an | d Number of | or Rural F | Baltimore | n, State Zio | 212 | 37 | |
| | 20a. METHOD OF DISPOSITION 1 | oval from Stata | 0b. PLACE AND DATE | OF DISPO | SITION (Nam | na of | 1 Mary | 9/12/94 E | CATION — C | City or Tox | vn, Stata | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | | ardens of | | | | | | | more | CO., My | |
| | 1 home 7/ | munker | eike | | | | | uneral Hom Ave. Balt | | M | 21221 | |
| | 23. PART I. Enter the diseases, or c | omplications that caus | ed the deeth. Do | not ente | r the mod | le of dyin | g, suci | as cardiac or respi | ratory arm | eat. | Approximate | |
| | shock, or heart failure. I IMMEDIATE CAUSE (Fine) | List affily one Couse Dn | eech line. | | | | | • | , | | interval Between Onset and Death | |
| - 1 | disease or condition resulting in death) | Compr | ession | ASI | hyxa | à | | | | | | |
| | resulting in death) | DUE TO (OR AS | A CONSEQUENCE C | OF): | | | | | | | | |
| Z | Sequentially list conditions, | λ | | | | | | | | | | |
| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS | A CONSEQUENCE O | F): | | | | | | | | |
| 은 | CAUSE (Disease or injury that initieted evente | DUE TO (OR AS | A CONSEQUENCE O | IF): | | | | | | | - | |
| E | reaulting in death) LAST | | | | | | | | | | | |
| | DART II OIL III III | | | | | | | | | - | | |
| PHYSICIAN: MEDICAL | PART II. Other aignificent condition | e contributing to deeth | but not resulting | in the u | nderlying | cause gi | ven In | Part i. 24a. WAS AN PERFOR | | 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | |
| ايَ | | | | | | | | 1 XYES 2 | □ NO | | OF DEATH? | |
| Σ | DID TOP A CCO LICE CONTR | UDULTE TO CALLER | | | = | | | | | | 1 X YES 2 NO | |
| AN | DID TOBACCO USE CONTR | GIBUTE TO CAUSE | 26. PLACE OF DEA | | | UNCE | RTAIN | 10] | | | | |
| 있 기 | EXAMINER? | HOSPITAL: | | OTHE | R: | - 21 | | | | | | |
| Ĭ | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 7 26h TIB | _ | 28c. INJU | | idenca | 8 Other (Specify) 28d. DESCRIBE HOW II | HILIBA OCC | HOED | | |
| | 1 Netural 5 Pending | (Month, Day, Year) 9/8/94 | 170 | JURY | WOR | IK? | NO | CAR FELLO | | | , l | |
| BY | 2 X Accident Investigation 3 Suictde 6 Could not be | 28a. PLACE OF INJUI | RY — At home, farm, | | ctory, office | | | 281 LOCATION (Street o | and Mumber | or Privat P | uda Mumbar | |
| | 4 Homicide detarmined | building, atc. (Sp | (IVE WAY | | | | | SIT PATUXE | BALT | 7 4100 | E MD | |
| ٦ | 29a. CERTIFIER 1 CERTIFYING PHYSIC | CIAN: To the best of my kno | | red at the | time, data a | nd place. | and due | | | | | |
| COMPLETED | | 3: On the basis of axeminat | | | | | | | | | and manner as stated. | |
| ш | 296. SIGNATURE AND TITLE OF CERTIFIER | | | | | 29c. LICEN | | | | | (Month, Day, Year) | |
| 0 | Nonald H. W. | ight MD | | | | | C.M | | ▶SE | | 09 1994 | |
| 임 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF C | , ,,,,, | , | | - | | | | | | |
| | DONALD G. WRIG | HT MD 1 | 11 Penn | Sti | ceet, | Ba | lti | more, Ma | ryla | nd | 21201. | |
| | 31. DATS EDMTH 901991 | 32. REGISTRAR'S SIG | | | | | | | | | | |

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REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH ANNA LOHER 09 09 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTIN (Morith, Day, Year) 03 10 6. AGE (In yrs. lest birthday) 5 SEY IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS 188-18-2059 1 M 2 TF 71 23 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN DIRECTOR NORTH ARUNDEL HOSPITAL ASSOCIATION RESIDENCE OF DECEMENT Pages 1, 2, 3 GLEN BURNIE 10b. COUNTY 10c, CITY, TOWN OR LOCATION MARYLAND ANNE ARUNDEL GLEN BURNIE permit. 10e. STREET AND NUMBER FUNERAL 101 ZIP CODE 322 WILSON BOULEVARD use as the burial-transit 21061 retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 22 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No-BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuber

1 YES 2 NO John, Mexican, Puerto Rican, atc.) Never Merried 2 Merried Specify: BY 3 Widowed 4 Divorced ETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 166. KIND OF BUSINESS/INDUSTRY (Specify only his Elementary/Secondary (0-12) funeral director, page 5 should be detached for College (1-4 or 5+) COMPL SALES CLERK RETAIL SALES 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) MICHAEL MAHONEY Ħ MARGARET BE MURPHY notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 KAREN M. EARLES 819 220TH STREET-PASADENA, MD. after death. Page 6 may be pe 20a. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must VETERANS MARYLAND" 4 Donetion 5 Other ecity) 9/13 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 21061 Q1 426 CRAIN HWY.S.W.GLEN BURNIE, MD. lied in by the medicai 23. PART t. Enter the diseases, or shock, or heart failure complications that caused the death of not enter List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest, 0 IMMEDIATE CAUSE (Fine) the diseese or condition reaulting in death) completely event, RECORDS, P.O. BOX 68760, DUE TO OR AS CONSEQUENCE OF) burial. traumatic CERTIFICATION and Sequentially list conditions, O OR AS A CONSEQUENCE OF if any, leading to immediate cause. Enter UNDERLYING attending physician phor CAUSE (Diseese or injury other TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 Health and Mental H PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL quires that any 1 YES ZE NO shows PHYSICIAN: Dept. Hem 23 25. WAS CASE REFERRED TO MEDICAL The 28. PLACE OF DEATH (Check only one) certificate t HOSPITAL **EXAMINER?** OTHER: T YES 2 XNO 1 Inpetiant 2 ER/Outpetiant 3 DOA 4 - Nursing Nome 5 - Residence 8 - Other (Specify) the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED with sius Netural 5 Pending Investigation 1 YES 2 NO DIRECTOR: After to hours after death v Item 28 is mark BY 2 Accident HOSPITAL OR ATTENDING 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 8 Could not be COMPLETED 4 Nomicide 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner ee stated. FUNERAL within 72 h 2 MEDICAL EXAMINER: On the TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: IS vestigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end menner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER BE XI

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

500

ELMO M. GAYOSO,

SEP 1

2 1994

31. DATE FILED (Month, Day.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

M.D./5411 OLD FREDERICK ROAD/BALTIMORE, MARYLAND 21229

FOR STATE REGISTRAR

0

3. TIME OF DEATH YEAR 94 9:40 PM 8. BIRTHPLACE (State or Foreign PENNSYLVANIA 9c. COUNTY OF DEATH A.A. COUNTY 10d. INSIDE CITY 1 YES 2 XNO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian, Black, White, etc. WHITE 21122 20c. LOCATION - City or Town, State CROWNSVILLE, MD. Approximate interval Between Onset and Death WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? t ☐ YES 2 ☐ NO N/A 281. LOCATION (Street end Number or Rural Route Number, City or Town, State)

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| IVISION | - |

| BALTIMORE, MARYLAND 21215-0020 | ICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | benefiticate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal. | e medical examiner must be notified at once. |
|--|--|--|---|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE HISPIT OF AN HOUNG PHYSICIAN: The law requires that the death certificate be executed within 24 | TO THE FUND AL PRECEDIT After this certificate has been signed by the attending physician and completely filled in by the fut be filled will at a property of the party of the filled will be a provided to the property of the pa | IMPORTANTAL ILEM 28.4 marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1 - FOR STATE REGISTRAR | OF MARYLAND / | DEPARTMENT (| F HEALTH AND I | MENTAL HYGIEN | | | |
|---------------|--|---|--|-------------------------------------|---|---------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) EMMA CHRISTINE | 1 | MUHLBACH | | 2. DATE OF OEATH | 994 YEAR | 5:20 am | |
| | 4. SOCIAL SECURITY NUMBER 213-74-2849 5. SEX 1 □ M 2 | | | EAR IF UNDER 24 HRS. AYS HOURS MIN. | 7. DATE OF BIRTH | 1897 Count | PLACE (State or Foreign | |
| TOR | 99. FACILITY NAME (If not institution, give street end nun Saint Joseph Hospital RESIDENCE OF DECEDENT | (ber) | | WHOR LOCATION OF DE | | 9c. COUNTY OF D | | |
| DIRECTOR | 100. STATE 10b. COUNTY BALTIMO | ORE CO | 10c. CITY, TOWN OR I | ocation TOWSON | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| FUNERAL | 100. STREET AND NUMBER 800 SOUTHERLY RD, | STROH HALL | | 101. ZIP CODE 2128 | 6 | 10g. CITIZEN OF | WHAT COUNTRY? | |
| ₽ | 3 → Widowed 4 □ Divorced IF YES, GIVE WAR OR DATES 1 □ YES 2 ★ NO Specify: WHI | | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | |
| | 12 17. FATHER'S NAME (First, Middle, Lest) EDWARD H. KLOPPEL | HC | <u>MEMAKER</u> | 16. MOTHER'S NA | ME (First, Middle, Maiden B | | | |
| TO BE | 190. INFORMANT'S NAME (Type/Print) J EDWARD MUHLBACH | 19b. | 8 WELL I | reet and Number or Rural I | | | | |
| | 20e. METHOD OF DISPOSITION SUBurlet 2 Cremetion 3 Removal from S 4 Donation 5 Other (Specify) | tets cametery crem | ND DATE OF DISPOSITION PROPERTY OF OTHER PROPERTY OF THE PROPE | N(Name of CEMETERY | 1 | CATION — City or TO | | |
| | 21. SIGNATURE OF FUNCTIAL EXPICE LIGHTER DEAN P CHARLTON | | cha | e and address of fa arlton F'U | NERAL HO | ME | ,MD 21231 | |
| | | ins that caused the dea ne cause on each line. | ith. Do not enter the | mode of dying, suc | h as cardlec or reepl | ratory arrest, | Approximate Interval Between Onset and Desth 2DAYS | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | DUE TO (OR AS A CONSEO | UENCE OF): | | | | | |
| MEDICAL (| PART II. Other significant conditions contribu CONGESTIVE HEART FAIL | | sulting in the unde | iying ceuse given in | Part I. 24a. WAS AN PERFOR | MEO? | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? | |
| | DEMENTIA / SICK SINUS DID TOBACCO USE CONTRIBUTE T 25. WAS CASE REFERRED TO MEDICAL | O CAUSE OF DEAT | | | N D | | 1 - YES 2 NO | |
| PHYSICIAN: | EXAMINER? HOSPIT | | OTHER: DOA 4 Nursing | Home 5 - Residence | 8 Other (Specify) | | | |
| ВУ РН | Natural 5 Pending Accident Investigation | ATE OF INJURY fonth, Day, Year) | INJURY M | WORK? | 28d. DESCRIBE HOW II | NJURY OCCUREO | | |
| | 4 Homicide determined | LACE OF INJURY — At homulding, etc. (Specify) | | | 281. LOCATION (Street a City or Town, State) | | Route Number, | |
| COMPLETED | 29e. CERTIFIER Check only one) CERTIFYING PHYSICIAN: To the be | | | | | | s) and manner as stated. | |
| TO BE | 296. SIGNATURE AND TITLE OF CERTIFIER | rehter y | mo | 29c. LICENSE NUM | IBER | 29d. DATE SIGNED | (Month, Day, Year) | |
| | JOGINDER P. MEHTA, MI | ST. JOSEPH | HOSPITAL | TOWSON, ME | 21204 | | | |
| | SEP1 2 1994 Jahi 32. RE | GISTRAR'S SIGNATURE | | | | | | |

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| Personal The law requires that the death certificate be executed within a nouns after death. Page 6 may be retained by the hospital or attending physician. | First community has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit | arked, or tem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OFFICE TO THE FUNERAL DIFFER DIFFER MIGH WITH TO THE MINER TO THE MINER THE MINER THE MINER TO THE MINER TO THE MINER TH

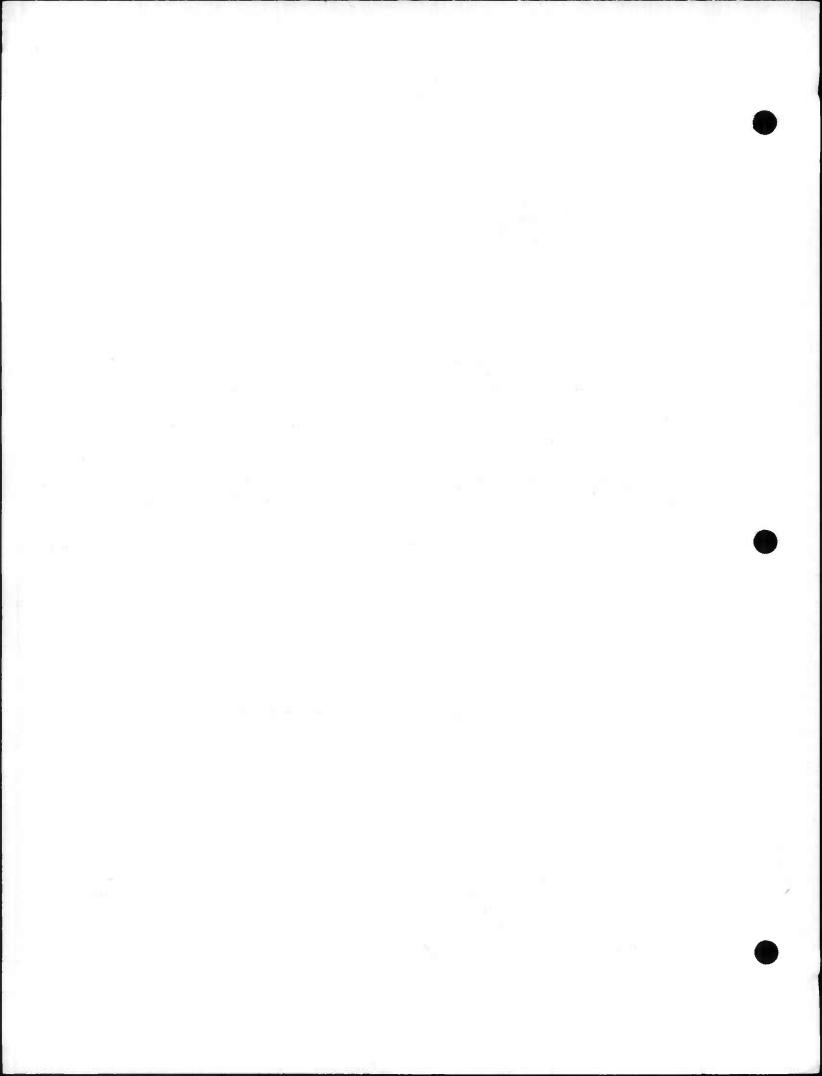
| | 1. DECEDENT'S NAME (First, | Middle, Last) | | | | | | | | 2. DATE OF MONTH | OEATH DA | | WEAR | 3. TIME OF DEAT | ГН | |
|-----------------------|---|-------------------------------|--|----------------|------------------------|--------------|-----------|--------------|------------|---------------------|-------------------|----------------------------|--------------|---------------------|---------|--|
| | D'WAIN | McI | EOD | | | | | | | SEPT | 04 | | 994 | 4:13 | P M | |
| | 4. SOCIAL SECURITY NUMB | ER | 5. SEX | 6. AGE (In yr | s. last birthday) | | ER 1 YEAR | | R 24 HRS. | 7. DATE OF | BIRTH W. March | | 6. BIRTI | IPLACE (State or Fo | oreign | |
| | 217-52-71 | .55 | 1 🔀 M 2 🗌 F | 44 | YRS. | MONTHS | DAYS | HOURS | MIN. | 2/24 | /195 | 0 | S. | "CAROLI | NA | |
| | 9e. FACILITY NAME (If not in | | | | | | | OR LOCAT | | | | 9c. COU | NTY OF D | EATH | | |
| DIRECTOR | 3205 MON | | IN AVEN | UE | | В | ALT | IMOF | E C | ITY | | | | | | |
| ᇤ | RESIDENCE OF DEC | 10b. COUNTY | | | I soc CIT | Y, TOWN | 08100 | ATION | | | | | | | | |
| ١٣ | MARYLAND | 1041 000111 | | | | | | ORE | | | | 10d. INSIDE CITY V LIMITS? | | | | |
| | 10e. STREET AND NUMBER | | | | | 17111 | | 10f. ZIP COL | \F | | | 10 - 017 | 1 YES 2 NO | | | |
| ₽ B | 3205 MONE | A TAIM T N | וואסונג ז | E . | | | - 1 | 1.7 | 121 | c | | 10g. CH | USZ | WHAT COUNTRY? | | |
| FUNERAL | 11, MARITAL STATUS | MITT | | | ARMED | 12 | WAS D | | | VIC ORIGIN? (S | | as No. | | E — American India | | |
| | 1 Never Married 2 | | 12. WAS DECEDER FORCES? IF YES, GIVE | | | 1 " | Il yes, | specify Cub | en, Mexica | n, Puerto Rica | | or No- | Blac | k, White, etc. | en, | |
| B | 3 Wildowed 4 A Divo | rced | 11/28/ | 72 97 | 3/74 | _ | 1 🗆 🚻 | ES 2 XNO | Specin | у. | | | Spec | BLACK | (| |
| COMPLETED | 15. DEC | EDENT'S EDUC highest grade | CATION completed) | 164 | . DECEDENT'S | USUAL | OCCUPAT | TION | 1 | 16b. KIP | D OF BUS | INESS/IN | DUSTRY | | | |
| <u> </u> | Elementary/Secondary (0 | | College (1-4 or 5 | +) | life. Do NOT u | se retired., |) | | ing | 7.1 | 1 (1) | 2+0 | Mor | | | |
| M M | 12th | | 1 + | | Stoc | k C | ler | K | | AI | T-20 | ate | MO | ving | | |
| 8 | 17. FATHER'S NAME (First, Mi | | | | | | | 16. MOT | HER'S NA | ME (First, Midd | le, Meiden l | Surname) | | | | |
| BE | HERMAN | MCLE | DD | | | | | r | HEL | MA Mc | FADI | EN | | | | |
| 2 | 19s. INFORMANT'S NAME (7) | | | | | | | | | Route Number, (| | | | | | |
| - | THELMA MC | | | | 3205 | MO | NDA | WMIN | AV | ENUE | BALT | 'IMO | RE, | MD 212 | 215 | |
| | 20e. METHOD OF DISPOSITI | | oval Irom State | 20b. PL/ | ACE AND DATE | OF DISPO | SITION | Name of 9 | /9/ | 94 DATE | | | - | own, State | | |
| | 4 Donetion 5 Other | | | Gar | rison | | | | | | Owi | ngs | Mi. | lls, MI |) | |
| - 1 | 21. SIGNATURE OF SUNERAL | IN / | THE PERSON | 1 | 11 | T. | ERO | Y O | ESS OF FA | ETT & | SON | FII | NER | AL HOME | 7 | |
| | PINA | WA | U. N | 415 | 11 | | | | | Y HEI | | | | | | |
| | 23. PART I. Enler the di | season, or o | complications the | it caused the | daath. Do | not ante | er tha m | node of dy | Ing, suc | h aa cardlac | or reapli | ratory an | reat, | Approxim | | |
| | IMMEDIATE CAUSE (Fin | | List only one car | use on each | lina. | | | | | | | | | Interval 8 | | |
| | disease or condition resulting in death) | | . NARCOTI | COCAI | INE AND | AL COL | IOI I | NEOVIC | ATTON | | | | | | | |
| | resulting in death) | | | | NSEOUENCE O | | IUL 1 | MIONIC | MILLON | | | | | 1 | | |
| z | | | h. | | | | | | | | | | | | | |
| 은 | Sequentially list conditi If any, leading to immed | | DUE TO | (OR AS A CO | NSEQUENCE O | F): | | | | | | | | | - | |
| <u>8</u> | cause. Entar UNDERLYI CAUSE (Disease or Inju | | c | | | | | | | | | | | | | |
| | that initiated events resulting in death) LAS | | DUE TO | (OR AS A CO | NSEQUENCE O | F): | | | | | | | | | | |
| MEDICAL CERTIFICATION | readiting in ogeth) LAS | | d | | | | | | | | | | | | | |
| 2 | PART ii. Other significa | nt condition | s contributing to | death but r | not resulting | In the u | ındariyi | ing cause | givan in | Part i. 24 | . WAS AN | AUTOPSY | 246 | . WERE AUTOPSY FI | INDINGS | |
| 5 | | | | | - 2 | | | | | | PERFOR | | | AVAILABLE PRIOR | TO | |
| | | | | | | | | | | — IV | YES 2 | □ NO | | OF DEATH? | | |
| | DID TOBACCO | USE C | ONTRIBLITE | TO CA | USE OF | DEA. | TH Y | YES [| NO | <u> </u> | | | | 1 YE\$ 2 | NO | |
| ₹ | 25. WAS CASE REFERRED TO | | | 10 0/ | .002 01 | | | | | eck only one) | | | | | | |
| | EXAMINER? | | HOSPITAL: | EB/Outpetle | or 3 🗆 004 | OTHE | R: | tool use on | A. 71 A | | | | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | | 28a. OATE OI | | 26b. TIN | | 1 | NJURY AT | ssidence | 6 Other (S) | | LIURY OC | CURED | | | |
| | | Pending | 9/4/94 | Day, Year) | FOUND | | V | VORK? | (XNO | | | | OUNED | | | |
| B | 2 Coloda | investigation | | OF INJURY — / | 4:05 At home, farm, | 1 | | | | UNKNOWN | | nd Numbe | r or Rural I | Ploute Number, | | |
| COMPLETED | - ~~ | Could not be determined | building | etc. (Specny) | | · | ,,, | | | City or To | wn, State) | | | TOOLS THE TOOL | | |
| 9 1 | 20 CENTIFIER | | | | ME | - | | | | 3205 MC | - | | | | | |
| 2 | | | CIAN: To the best o | | | | | | | | | | | | | |
| ខ្ល | | | R: On the bests of e | examination so | d/or investigation | on, In my | opinion, | death occu | red at the | time, dete end | l place, end | due lo ti | he cause(s | s) end manner as a | tated. | |
| # /I | 296. SIGNATURE AND TITLE | F CERTIFIER | m | 1 | Y. 1. | 1 | | | ENSE NUI | | | | | (Month, Day, Year) | | |
| ٥(ا | 2 chan | - will | 114 /0 | - 4 | Un | | | 0. | C.M | .Е. | | ▶ S | EPT | 05,199 |)4 | |
| | | | | | | | | | | | | | | | | |
| | Donald G. | Wrig | bt M.D. | - 4 | 111 P | enn | St | reet | , B | altim | ore, | Ma | ry1 | and 212 | 201 | |
| | 2551 S | 194 A | 32 Heistl | A. T. | 24 | | | | | | | | | | | |
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| | n. | 1. DECEDENT'S NAME (First | t, Middle, Lest) | · . | | | | | | | 2. DATE | OF DEATH | | YEAR | 3. TIME OF DEATH | |
|--|----------|--|--------------------------|---------------------------|-----------------------------------|--------------|------------------------------------|-------------|----------------------|------------|------------|-------------------------------------|--|-------------------|-----------------------------------|----------|
| , | 731 | Leah Pat | | | r | | | | | | | | | 94 | _5:30 P | M |
| | | 4. SOCIAL SECURITY NUMI | | 5. SEX | 6. AGE (In yrs. le. | | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | (Mannt | OF BIRTH | | Country | | |
| phous | | 212-32-500 | | 1 M 2 X F | 80 | YR\$. | | - | | | | ary 21, | 1914 | | nsylvania | |
| n | E I | 1168 Lind | | | | | | but | OR LOCATI | ON OF DE | AIR | | | timo | | |
| 1, 2, | 5 | RESIDENCE OF DEC | | | | | | | | | | | D0.1 | CIMO | | |
| Page | DIRECTOR | Md . | 106. COUNT | altimore | | | oc. city, town or location Arbutus | | | | | | | | 10d. INSIDE CITY LIMITS? | |
| erait. | | 10e. STREET AND NUMBER | | | | UT | | | | | | 10a, CITI | 1 YES 2 X NO | | _ | |
| nsit p | FUNERAL | 1168 Linde | en Ave | • | | | | | 21227 | 7 | | | - | | USA | |
| physician. burial-tran | FUN | 11. MARITAL STATUS 1 Never Merried 2 | an-dia | 12. WAS DECEDEN | IT EVER IN U.S. AF | RMED | | | | | | 1? (Specify Yes Ricen, etc.) | or No- | 14. RACE Black | - American Indian, White, etc. | |
| ending physician. as the burial-transit permit. Pages | BY | 3 X Widowed 4 Dive | | | MAR OR DATES | | | | 2XXNO | Specify | | | | Specify | white | |
| Se att | ED | | CEDENT'S EDU | CATION | 16a. DI | ECEDENT'S | | | ON ost of working | 27 | 166 | . KIND OF BUS | INESS/IND | USTRY | MITCE | |
| for u | LET | Elementery/Secondary (| | College (1-4 or 5 | +) | i. Do NOT u | se retired.) | | JSC OF WORKE | 9 | | 0 | | | | |
| the hospital or att detached for use once. | COMPLET | 17. FATHER'S NAME (First, N | fiddle Last) | 2 | | Home | пакеі | | 10 MOT | HEO'S MA | ME /First | UWN Middle, Malden | Home | | | |
| | ш | Francis | | ynn | | | | | | | | Cubbi | 11.00 | | | |
| 5 should be | TO B | 19e. INFORMANT'S NAME (| | | 19 | b. MAILING | ADDRESS | S (Street a | and Number | or Rural I | loute Num | ber, City or Town | n, State, Zip | Code) | | |
| y be re page 5 | - | Gary L. Ka | | 1 | | | | | | . El | | ge, Mo | | 1227 | | |
| death. Page 6 may be retained by funeral director, page 5 should be examiner must be notified at | | 1 X Burlel 2 Dremati | in a □ Bein | over from State | 20b. PLACE cemetery, cri | emetory or o | ther place! | | | | 9/12 | 20c. LO | T+ i m | City or Tow | m, State | |
| ral din | | cometery, crematory or other place) Loudon Park Cemetery Loudon Park Cemetery 21. SIGNATURE OF JUNETAL SERVICE LICENSEE LOUdon Park Cemetery Cemetery or other place) LOUdon Park Cemetery Cary L. Kaufman Funeral Home of Elk., Inc. | | | | | | | | | | | | | | |
| 9 7 | | 1/4/ | 1 | | _ | | | - | | | | eral F ridae. | | | , | |
| rs af | | 23. PART I. Exter the d | iseppes, or | complications the | it caused the deuse on each illu | eeth. Do | not enter | the mo | da of dy | ing, suci | ss can | liac or respi | ratory srr | est, | Approximate Intervel Between | |
| illed in, o | | IMMEDIATE CAUSE (Final disease or condition) Oracle Acros and and Adams | | | | | | | | | | | | | | |
| ompletely fille ompletely fille II, cremation, event, the | | resulting in death) | → | S. DUE TO | OR AS A CONSE | OUENCE O | F): | (00 | 740 | | | | | | hour | _ |
| executed within and completely for burial, cremation matic event, the | z | Cognostially list condit | | b | | | | | | | | | | | | |
| ertificate be execute ring physician and c giene prior to buria other traumatic | CATION | Sequentially list condit if sny, leading to imme cause. Enter UNDERLY | dieta | DUE TO | (OR AS A CONSE | OUENCE O | F): | | | | | | | | | |
| n certificate be inding physician Hygiene prior to other traur | RTIFIC | CAUSE (Disesse or injuthat initiated events | | c. DUE TO | (OR AS A CONSE | OUENCE O | F): | | | | | | - | | | |
| o Tage | ши | resulting in death) LAS | 5T | d | | | | | | | | | | | | |
| 9 9 5 | IL C | PART II, Other significant conditions contributing to death but not resulting in the underlying couse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | | | | | | | |
| thai thai | DICAL | (aur gol | Car | anore. | | | | | | PERFORMED? | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | |
| | ME | | | | | | | | | | | • | | | 1 TYES 2 NO | |
| w reg | AN | DID TOBACC | | CONTRIBUT | E TO CAL | SE O | F DEA | | |] NC | | | | | | _ |
| | Sie | EXAMINER? | O MEDIONE | HOSPITAL: | ER/Outpatient | 3 □ DOA | OTHER 4 Nur | R: | ACE OF D | | | | | | | |
| | 1 | 27. MANNER OF DEATH | | 28e. DATE Of (Month, L | FINJURY | 28b. TIN | _ | 28c. IN. | JURY AT | Jaioarka | | CRIBE HOW I | NJURY OCC | CURED | | \dashv |
| E FE E | ВУ | t Natural 5 2 Accident | Pending Investigation | P | 12 | | M | 1 🗌 | YES 2 | NO | | | | | | |
| TENOT POR A | B | 3 Suicide 8 4 Homicide | Could not be determined | 28e. PLACE (building | OF INJURY — At he, atc. (Specify) | ome, farm, | street, tact | ory, offic | en . | | | ATION (Street of or Town, Stete) | nd Number | or Rural Ad | oute Number, | |
| DOM: | 9 | 29a. CERTIFIER 1 CERT | TIFYING PHYS | CIAN: To the best o | f my knowledne d | eath occur | and at the t | ime dete | and place | and due | to the sec | unafa) and man | | | | - |
| HOSPEAL FUNERAL WITHIN | 8 | | | | | | | | | | | | | | and menner as stated. | |
| TO THE HOSP TO THE FUNE De filed within | O I | 29b. SIGNATURE AND TITLE | of CERTIFIE | 1 | | | | | | ENSE NUA | | | 29d. DAT | E SIGNED | (Month, Day, Year) | \dashv |
| 5 6 3 W | 0 8 | Wares Sylver | a) | 20 | | | | | 02 | 416 | 1 | | 19 | 19/4 | 74 | |
| | | 30. NAME AND ADDRESS O | | By , O | | M 27) (Type | , Print) | | | | | | | 4 | | |
| | | 31. DATE FILED (Month, Day, | | | AR'S SIGNATURE | | | | | === | | | | | - | - |
| | | SEP 12 | 1994 | Julia Dan | idem-Road | ساس | | | | | | | | | | |
| _ | | | | U | | | | | | | | | | | DHMH-18 Rev | 1/89 |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



HIML OR KETENDING PROSICIAN. The law mounts that death certificate be executed within the four after death. Page 6 may be retained by the hospital or attending physician.

Page 6 may be retained by the hospital physician and competing filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be a marked, or fleath and where the permit is returned by the medical examiner must be marked, or fleath as a marked, or fleath and marked or fleath and marke BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

| tem # 1 Film | # G 715 | 09-12-94 N | .A. | Per Fur | neral | Home |
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| | 1 - STATE REGISTRAR | STATE UP I | MAHTLAN | | | OF DEA | | IENTAL HYGIEN REG. NO. | E | | |
|---|--|---|--------------|--------------------|--------------|-----------------------------------|-------------------|---|------------|--------------|-----------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, La | st) | | | - CATE | OI DEA | | 2. DATE OF DEATH | | | 3. TIME OF DEATH |
| | VERNARD - | MAPLES M | lople | | | | | SEPT 05 | | YEAR | 12:20 A M |
| 1 3 | 4. SOCIAL SECURITY NUMBER | 5. SEX | | rs. last birthday) | IF UNDER | | 24 HRS. | 7 DATE OF BIRTH | | a. BIRTHP | LACE (State or Foreign |
| | 218-76-7429 | 1X M 2 F | 27 | YRS. | MONTHS | DAYS HOURS | MIN. | 10 - 25 - 6 | 5° MD | | |
| | 9a. FACILITY NAME (If not institution, gi | | | | 9b. CITY, | TOWN OR LOCATI | ON OF DEA | АТН | 9c. COU | NTY OF DEA | ATH |
| P | 900 BLK HARI | EM AVE | | | B | ALTIMO | RE C | ITY | | | |
| DIRECTOR | 10a. STATE 10b. COU | | | 10c. CIT | Y, TOWN O | R LOCATION | | | | 1 | IOd. INSIDE CITY |
| | MD | | | BA | LTO | | | | | ١, | LIMITS? |
| 3AL | 10e. STREET AND NUMBER | | | | | 10f. ZIP COD | E | | 10g. CITI | ZEN OF WH | AT COUNTRY? |
| FUNERAL | 648 HILLVIEW RD 21225 U.S.A. | | | | | | | | | S.A. | |
| | 11. MARITAL STATUS XIX Never Married 2 Married | 12. WAS DECEDEN FORCES? 1 | YES 2 | 2 NO | - 81 | yes, specify Cubs | n, Maxican | C ORIGIN? (Specify Yes, Puerto Rican, atc.) | or No- | | - American Indian, White, etc. |
| A | 3 Widowed 4 Divorced | IF YES, GIVE V | WAR OR DATES | s | 1 | ☐ YES 2 📉 NO | Specify: | | | Specify: | BLACK |
| COMPLETED | 15. DECEDENT'S E (Specify only highest gr | DUCATION | 16: | a. DECEDENT'S | USUAL OC | CUPATION uring most of working | | 16b. KIND OF BUS | INESS/INC | DUSTRY | |
| <u> </u> | Elementary/Secondary (0-12) | College (1-4 or 5 | | life. Do NOT us | e retired.) | uning most of workii | rg | | | | |
| MP | 12th | | | JNKNOW | N | | | | NWON | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) ERNEST MAPLE | 1 | | | | | HER'S NAM GLOR | E (First, Middle, Maiden | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | | 195 MAILING | ADDRESS | | | oute Number, City or Town | | 0-7-1 | |
| TO BE COM | LINDA DAV | IS | | | | | | BALTO, M | | | |
| | 20a. METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 R | emovel from State | 20b. PL | ACE AND DATE (| OF DISPOSI | FION (Name of | | OATE 20c. LOC | CATION — | City or Town | n, Stata |
| | 4 Donation 5 Other (Specify) | | - WO | ODLAW | N C | EMETER | Y | 91094 W | 100D | LAWN | MD |
| 100000000000000000000000000000000000000 | 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE | |) | | AME AND ADDRE | | | | | |
| | Mlady | o Wa | nen | | | ARCH F | | | | | AVE |
| | 23. PART i. Entar the diseases, ahock, or heart failu | or complications that ra. List only one cau | t caused the | a death. Do n | ot antar t | the mode of dy | ng, auch | as cardiac or respin | ratory arr | est, | Approximata interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | Mul | 4:0 | 1. | | 1.6 | -/1 | 1 | | | Onset and Death |
| 7 | resulting in death) | a. Pure m | 1110 | PINSEQUENCE OF | 11011 | Short | 1 | winds | | | Minutes |
| | | - Due 10 | (OH AS A CO | NSEQUENCE OF | ·): | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO | (OR AS A CO | NSEQUENCE OF | ·): | | _ | | | | İ |
| OA | CAUSE (Disease or Injury | 6. | | | | | | | | | |
| H. | that initiated events resulting in death) LAST | OUE TO | (OR AS A CO | NSEQUENCE OF | 7): | | | | | | |
| | The state of the s | | | | | | | | | | - |
| CAL | PART II. Other significant condit | ions contributing to | death but r | not resulting i | n tha und | larlying cause | iven in P | art I. 24s. WAS AN PERFOR | | | VERE AUTOPSY FINDINGS |
| 90 | | | | | _ | | | 1 YES 2 | □ NO | C | OMPLETION OF CAUSE OF DEATH? |
| MED | | | | | | | | | | 1 | ES 2 NO |
| AN | DID TOBACCO USE CON 15. WAS CASE REFERRED TO MEDICAL | | | PLACE OF OBAT | | | ERTAIN | | | | |
| PHYSICIAN: | EXAMINER? 1 YES 2 NO | HOSPITAL: | | | OTHER | | | 37 | | | |
| H | 27. MANNER OF DEATH | 28s. DATE OF | INJURY | 28b. TIMI | OF : | RSc. INJURY AT | | | JURY OCC | | , |
| ву р | 1 Natural 5 Pending 2 Accident Investigation | 9 9 5 | 79 | 4 UN | Z M | WORK? | NO " | Found | 5 | hot | |
| | 3 Suicide 6 Could not | 29s. PLACE O | Spetito | t home, term, s | treet, facto | ry, office | 1 | 28f. LOCATION (Street & City or Town, State) | nd Number | or Rural Rou | ite Number, |
| E | 4 Homicide determined | 90 | D D |)LK- | 1/191 | 5 C GM | ME | LYING | on | PAT | PEMENT |
| OMPLETED | | Y JOHN: To the beat of INES: On the beals of a | | | | | | | | | nd manner as stated. |
|) | 290. SIGNATURE AND TRUE OF CERTIF | Tua | le | 20 | | | C.M. | | | | forth, Day, Year) 05,1994 |
| 2 | 30. NAME AND ADMINESS OF PERSON | AHO COMPLETED CAUS | SE OF DEATH | 1117 P | enn | Street | , Ba | ltimore, | Ma | ryla | nd 21201 |
| | 31, DATE FILED (Month, Day, Year) | 32. REGISTRA | A'S SIGNATUR | HE | | - | | | | | |
| | SEP 1 2 1994 | 4 | er er er er | | | | | | | | |

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| | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPART | MENT OF H | EALTH AND DEATH | MENTA | AL HYGIENE REG. NO. | | | | |
|--------------|---|---|--|------------------|--|---|--------------------------------------|--------------|--|--|--|
| | 1. DECEDENT'S NAME (** Middle, Last) 4. SOCIAL SECURITY NUMBER | Toyer | Letitia | May Mo | yer | моу | OF DEATH DAY | 74 | 3. TIME OF DEATH | | |
| | 207 03 0049 | 8. AGE (1 | | ONTHS DAYS | HOURS MIN. | May | th Day, Year, 1900 | 6. BIRTH | PLACE (State or Foreign y) enna. | | |
| OR | 9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore 9c. COUNTY OF DEATH — | | | | | | | | | | |
| 딚 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 100 CITY | TOWN OR LOCAT | FION | | | | | | |
| . DIRECTOR | Maryland Car | rroll | | New Wir | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 1 NO | | |
| FUNERAL | 100. STREET AND NUMBER 3845 Sams Cre | eek Rd. | | 101 | 21776 | | _10g. C | ITIZEN OF V | WHAT COUNTRY? | | |
| B | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 K NO | 13. WAS DEC | 14. RACI Black Spec | E — American Indian, k, White, atc. th: White | | | | | |
| PLETED | 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) | | life. Do NOT use i | k done during mo | ON sst of working | 16 | b. KIND OF BUSINESS/ | NDUSTRY | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | AME (First. | Middle, Maiden Surname |) | | | |
| ш | Joseph Mad | cNeer | | | El | _ | Braght | | | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) Dorothy Colandro | Daughter | | eachwoo | | | nber, City or Town, State, | | 2 | | |
| | 20a. METHOD OF DISPOSITION | 20b. | PLACE AND DATE OF CHARLES THE CECAR HI | DISPOSITION (Ne | ame of | DAT | TE 20c. LOCATION | — City or To | wn, Stata | | |
| | 4 Donation 5 Other (Specify) | | cedar ni | 22. NAME AN | ND ADDRESS OF FA | 9/13/ | | | , Pa. | | |
| | mu E | mydeen | -ki | | | | eral Home . Balto. | | 21 221 | | |
| | 23. PART I. Enter the diseases, or conshock, or heart failure. L. IMMEDIATE CAUSE (Final disease or condition resulting in death) | Schen | consequence of | | Lalls | | | errest, | Approximate Interval Between Onset and Death | | |
| ERTIFICATION | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| : MEDICAL C | PART II Other significant conditions contribution to death but not resulting in the underlying cause given in Part I. PART II Other significant conditions contribution to death but not resulting in the underlying cause given in Part I. PERFORMEDY 1 VES 2 NO 246. WAS AN AUTOPSY PERFORMEDY 10 11 | | | | | | | | | | |
| SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINERT | HOSPITAL: | | THER: | ACE OF DEATH (C) | | e.Wester | | | | |
| PHY | 27. MANNER OF DEATH 1 Natural S Pending | 28s. DATE OF INJUSTY (Month, Day, Hear) | 285. TIME C | OF 28c. INJ | WE S Medidence | | er (Spilloty) SCRIBE HOW INJURY C | CCURED | | | |
| тер ву | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide ifebruirsed | 28e. PLACE OF INJURY building, etc. (Speci | | | CATION (Street and Hund or Reen, State) | er or Rusel F | Room Number | | | | |
| COMPLE | 29s. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as atsted. | | | | | | | | | | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | RERENZO | | | 29c. LICENSE NU | | 29d. D | ATE SIGNED | (Month, Day, Year) | | |
| 10 | 30. NAME AND ADDRESS DE PERSON WHO MONORMAN S. () | Berugi - 5 | BUI Lock | im) Roever | | | hmore , H | 11 2 | 1235 | | |
| | 31. DATE FILSEP 1994 | 32 AEGISTRAR'S SIGNA | TURE | | V-551 / | <u></u> | | 11 | | | |

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rogenyland Funeral ness in

5:15

8. BIRTHPLACE (State or Foreign

10d. INSIDE CITY

14. RACE — American Indian, Black, White, atc. Specify: White

1 YES 2 X NO

Maryland

Α

21222

Interval Between

Onset and Death

QYEAR

Baltimore

USA

Pages 1, 2, 3 should

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DIRECTOR

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CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

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25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2

27. MANNER OF DEATH

1 Natural
Accident

3 Sulcide

4 Homicide

NO

5 Pending

8 Could not be

Investigation

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| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, be filled within 72 hours after death with the State Deot, of Health and Mental Hotiere prior to burfal, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner mus |
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH - 1^{DAY} -MIITR Chauncey 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 10/2/1921 IF UNDER 1 YEAR IF UNDER 24 HRS 220-05-7520 1 X M 2 | F 69 DAYS HOURS VRS 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Franklin Square Hsop. RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 10b. COUNT Baltimore Md. Dundalk 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 1618 Four Georges Ct. B-2 21222 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puarto Rican, aic.)

1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 N Divorced 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) 7th College (1-4 or 5+) Brakeman Railroad 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Roland Muir Elizabeth Zozk 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosa C. Muir 1618 Four Georges Ct. B-2 Balto. Md. 20a. METHOD OF DISPOSITION
1 ☐ Burlel 2 X Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION --- City or Town, Stata DATE cemetery, crematory or other place)
Metro Crematory 9/12 Baltimore, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Connelly FUneral Home of Dundalk 7110 Soilers Pt. Rd. Dundalk 21222 23. PART I. Enter the diseases, or complications that caused the shock, or heart feliure. List only one cause on each line with. Do not enter the mode of dying, auch as cardiac or respiratory arrest, **IMMEDIATE CAUSE (Final** disease or condition_ Sepsis reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditione, DUE TO (OR AS A CONSEQUENCE OF): If eny, laeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) thet initiated events reaulting in deeth) LAST PART il. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY Chronic atrial fibrillation 1 YES 2 Disseminated intravascular coagulation Pneumonia

PERFORMED? NO.

28d, DESCRIBE HOW INJURY OCCURED

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

09

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 YES 2 NO

| OA CERTIFIER | |
|--------------|--|
| De CENTIFICH | 1 CERTIFYING PHYSICIAN: To the heat of my knowledge, death convend at the three date and also and |
| (Check only | 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated |
| one) | A CAMPOON EVANORED OF THE CAMPOON OF |

28a, PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify)

28b. TIME OF

| 2 MEOICAL EXAMINER: On the basis of examination and/or investigation, in | n my opinion, death occured at the time, data and p | eleca, a | nd due to the cause(s) end manner se stated. |
|--|---|----------|--|
| | | | / |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | AND A LOCALOG AN ANDRON | | |

28c. INJURY AT WORK?

1 YES 2 NO

OTHER:

28. PLACE OF DEATH (Check only one)

4 Nursing Home 5 Realdence 6 Other (Specify)

Mathews 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

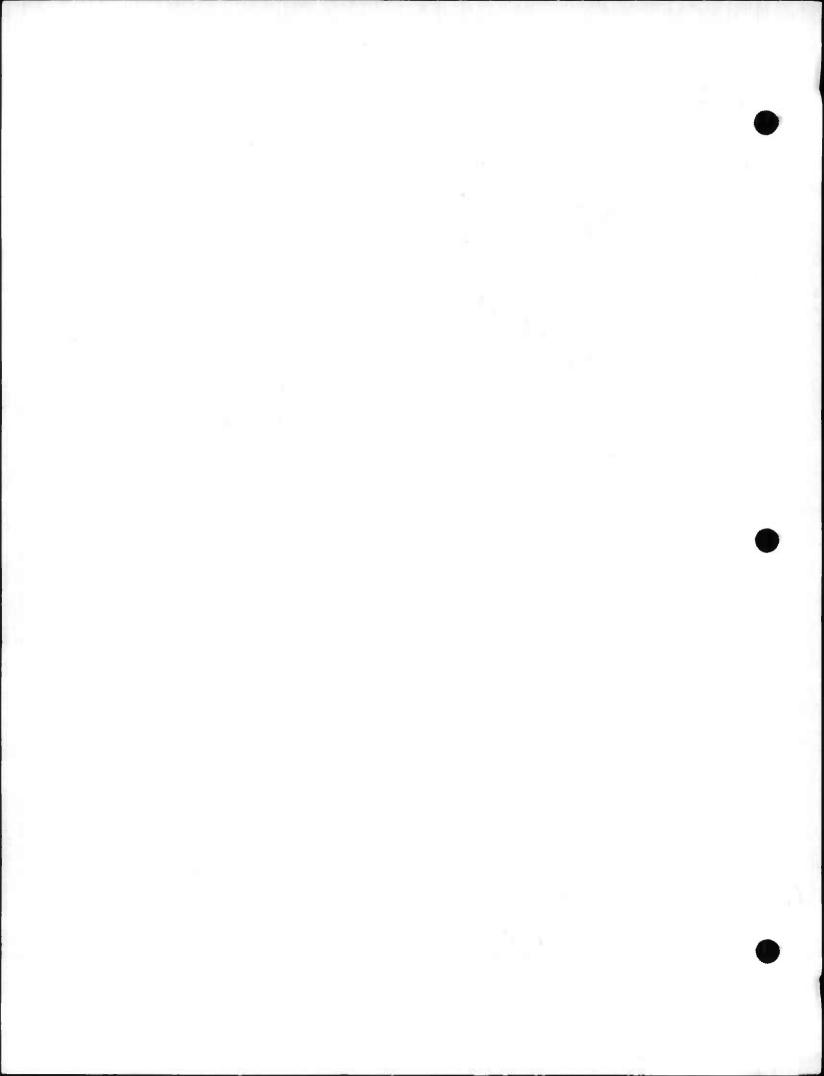
HOSPITAL

Inpetient 2 - ER/Oulpetient 3 - DOA

DATE OF INJURY

Dr Liji Mathew MD 9000 Franklin Square Drive Baltimore Maryland 21237

32. REGISTRAR'S SIGNATURE SEP 1 2 1994



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| BALTIMORE, MARYLAND 21215-0020 | mours after death. Page 6 may be retained by the hospital or attending physician. | Certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should | or removal. | medical examiner must be notified at once. | |
|--|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE HOSPITAL OR ATTENDING PHYSICIANS The law requires that the death certificate be executed within shours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this Certificate has been signed by the attending physician and completely fill | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | |

| STATE OF MAI | RYLAND / DEPARTMEN | T OF HE | ALTH AND | MENTAL | HYGIEN |
|--------------|--------------------|---------|----------|--------|----------|
| | CERTIFICAT | E OF D | DEATH | | REG. NO. |

| | 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO. | | | | | | | |
|--|---|---|---|------------------------------|-----------------------------------|---|--------------------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Lest) Leonard James M | * | | | 2. DATE OF OEATH SEPTEMBER 7, 199 | | | |
| TOR | | 5. SEX 6. AGE (In yrs 12 | | ONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTYN DEC . 23, | L936 | BIRTHPLACE (State or Foreign Country) Pennsylvania |
| | 2266 Dairy Farm | . FACILITY NAME (If not Institution, give street and number) 2266 Dairy Farm Road Gambrills | | | | ATN | 9c. COUNTY OF OEATH Anne Arundel | |
| DIRECTOR | 10a. STATE Anne Arundel Gambrills | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 XNO | |
| FUNERAL | 10e. STREET AND NUMBER 10f. ZIP CODE | | | | | 10g. CITIZE | N OF WHAT COUNTRY? | |
| JNE | 2266 Dairy Farm | N ROAD 12. WAS DECEDENT EVER IN U.S | ARMED | | 1054 | IIC ORIGIN? (Specify Yes | USA | . RACE — American Indian. |
| BY | 1 Never Married 2 Married 3 Wildowed 4 Divorced | FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | NO | If yes, sp | 2 NO Specify | n, Puario Rican, etc.) | or No _ 14 | Black, White, atc. Specify: White |
| COMPLETED | 15. OECEDENT'S EDUCA' (Specify only highest grade co Elementary/Secondary (0-12) | ompleted) College (1-4 or 5+) | Give kind of work life. Do NOT use n | k done during mo etired.) | | 16b. KIND OF BU | | |
| MP | 12 | Estimator Const | | | | truction | | |
| BE CO | 17. FATNER'S NAME (First, Middle, Lest) Leo Mis | sko | | | | ME (First, Middle, Maiden A Yinglir | | |
| 10 | 190. INFORMANT'S NAME (Type/Print) Martha Rita Mis | sko . | | | | noute Number, City or Tow d, Gambri | | |
| | 20a. METNOD OF DISPOSITION 1 Burlat 2 Cremation 3 Remove 4 Donation 5 Other (Specify) | al from State 20b. PLA | CE AND DATE OF I | osposition (Na | ans Cer | DATE 20c. LO | | or Town, Stata |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | 21/ | | | | neral Hon Ave. Anna | | .A. s, MD 21401 |
| | 23. PART I. Enter the diseases, or con shock, or heart fellure. Lie | mplications that caused the et only one cause on each | deeth. Do not line. | enter the mo | de of dylng, sucl | n aa cardlac or reep | iratory arrea | t, Approximate interval Between |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) | Metastat DUE TO (OR AS A COM | IC E | ropheg | eal Co | rcinoma | | Onsat and Death |
| NO | Sequentially list conditions, DIE TO OR AS A CONSEQUENCE OF | | | | | | | |
| FICAT | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | | | | | | | |
| Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events reaulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d | | | | | | | | |
| PHYSIGJAN: MEDICAL | PART II. Other eignificent conditions | contributing to death but n | ot resulting in t | the underlying | ceuse given in | Part i. 24a. WAS AN PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| ME | | | | | | _ / | | OF DEATH? 1 YES 2 NO |
| IAN | DID TOBACCO USE CONTRII | | LACE OF DEATH | | UNCERTAIN | 1 🗆 📗 | | |
| YSIC | 1 YES 2 NO | OSPITAL: | | THER: Nursing Nom | e 5 Residence | 6 Other (Specify) | | |
| | 27. MANNER OF DEATH Natural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | | RK? | 28d. DESCRIBE NOW I | NJURY OCCUP | RED |
| ED BY | 2 Accident Investigation 3 Suicide 8 Could not be determined | 28s. PLACE OF INJURY — A building, atc. (Specify) | t home, term, stre | | | 281. LOCATION (Street I City or Town, State) | and Number or | Rural Route Number, |
| Suitcide Solicide | | | | | | | | |
| one) 2 MEDICAL EXAMINER: On the besis-of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and dus to the cause(s) and manner as stated. | | | | | | | | ause(s) and manner as stated. |
| 296. SIGNATURE AND TITERIOF CENTIFIES 296. LICENSE NUMBER | | | | | 29d. DATE S | GNED (Month, Day, Year) | | |
| 2 | John P. Serlant 1505 180 Admind Cachrone Dr., Annapolis MO | | | | | | | |
| | SEP 1 2 1994 | 2: REGISTRAR'S SIGNATUR | E : | | | |) " | 1 |

